Culture, Spirituality and Religious Literacy in Healthcare

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Chapter 7

Muslim women caregivers in elderly care in Finland

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7 Muslim women caregivers in elderly care in Finland

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Introduction and background

Muslims are the fastest-growing religious group in the world (Attum et al., 2022; PEW, 2015). Due to recent migration flows, Finland, like the other Nordic countries, has a large number of foreign-born care professionals working in elderly care, many of whom are Muslims. To date, no research has been done in the Finnish healthcare system that would provide an understanding of Muslim care professionals' needs and the challenges they face in the care workforce. A better understanding of their experiences in the workplace could illuminate some culture-specific aspects of everyday nursing practices. The present study examines the values and issues involved in Muslim professionals delivering practical care to elderly people. Drawing on the experiences of 21 informants – Muslim as well as non-Muslim – it outlines the obstacles and challenges that such work poses for Muslim healthcare professionals as well as their expectations regarding the work. The research seeks to enhance awareness and understanding of the values expressed by Muslim healthcare professionals who work in care homes. In short, this chapter aims to identify forms of discrimination against Muslim caregivers in Finland and to gain knowledge about what role cultural interaction and religious values play in the elderly care sector.

The elderly care sector is becoming highly multicultural, a development requiring an awareness of diverse faiths and beliefs (Rassool, 2015). This being the case, all healthcare professionals are required to have an increased sensitivity to "religion" and "culture" if they are to overcome misunderstandings and even conflicts in everyday healthcare encounters. The argument is that this sensitivity is necessary for all care professionals from managers to caregivers, including Muslim caregivers. It has been claimed that Western nursing perspectives are not always consistent with the cultural and religious beliefs of Muslim care professionals (Begum & Seppänen, 2017). With reference to these and similar understandings in previous research, the present study sets out to contribute to transcultural nursing, specifically to the emerging body of cultural knowledge that will benefit nurses in a variety of cultural contexts.

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Due to the rapidly growing ageing population in many countries, the demand for caregivers is increasing (Stone, 2016: 99). The work is physically stressful, and in Finland, for example, recruiting care workers has become challenging (Hellstén, 2014). Despite the increasing demand, the salaries in the elderly care sector are low, there is increased reliance on immigrant workers (Olakivi, 2018; Olakivi & Wrede, 2021) and working environments tend to be unattractive (Aalto et al., 2013; Nieminen, 2011; Tehy, 2012). In Helsinki, the proportion of migrants working as registered or practical nurses increased from 4 per cent to 11 per cent in the period from 2004 to 2013 (Olakivi, 2018: 14). Given the urgency of the situation, recruitment tends to ignore the true skills, competencies and interests of migrant workers (Näre, 2013). These trends in caregiving suggest that migrants are likely to end up working in poor conditions (Nieminen, 2011; Olakivi, 2018) and will be unequal in status in comparison with non-migrant workers. Some of the immigrant nurses reported differences in professional cultures and cultural differences in Finland. They felt uncertain about their integration in Finland (Pentinmäki, 2014).

Both culture and religion can have a great influence on workers in the elderly care sector. Few studies have been done in Finland on healthcare professionals (Emami & Safipour, 2013; Kaihlanen et al., 2019) to examine the challenges that they face (Balasubramaniam et al., 2018). Researchers have explored the experiences of Muslim women as *recipients* of healthcare (Firdous et al., 2020). Familiarity with the experiences of Muslim *caregivers* and their needs and expectations will contribute to creating an inclusive working environment.

The next section discusses cultural and religious literacy, competence and rights that may figure significantly in elderly care surroundings.

Cultural and religious literacy, cultural competence and rights in intercultural care settings

There are many different understandings of the relationship between religion and culture. According to Mariam Rawan Abdulla, the relationship is "revealed in the motivation and manifestation of cultural expression. If culture expresses how humans experience and understand the world; religion is a fundamental way in which humans experience and understand the world" (Abdulla, 2018: 107). Similarly, Zimmermann (2017) claims that "[c]ulture is the characteristics and knowledge of a particular group of people, encompassing language, religion, cuisine, social habits, music and arts". The inseparability of culture and religion is also one key aspect stressed by Harvard's Religious Literacy Project (Harvard, 2023). Diane L. Moore (2007: 56) has asserted, "Religious literacy entails the ability to discern and analyse the fundamental intersections of religion and social/political/cultural life through multiple lenses". Adam Dinham and Matthew Francis (2015: 257, 266, 270), for their part, have described religious literacy as "a stretchy, fluid concept that is variously configured and applied in terms of the context in which it

happens … that must be adapted as appropriate to the specific environment". Cultural competence requires gaining knowledge about cultural norms and religious expectations (Campinha-Bacote, 2002; Johnson et al., 2017).

In the elderly care sector, the lens of cultural competence reveals social and cultural factors that influence the care beliefs and behaviours of care professionals. Jirwe et al. (2006: 6) define cultural competence as "an awareness of diversity among human beings; an ability to care for individuals; non-judgmental openness for all individuals and; enhancing cultural competence as a long-term continuous process". However, this notion is mainly used in nursing education only with reference to the well-being of multicultural clients and their needs and expectations. It stands to reason that the concept should be applied to promote the well-being of multicultural caregivers as well.

Care professionals (both native and immigrant) should be aware of the different cultural meanings and knowledge (Johnson et al., 2017; WHO, 2008). A number of variables, such as geography, climate, traditions, religion and cultural values, may influence how well care professionals adapt to work in a particular home, hospital or organization (Johnson et al., 2017). Cultural awareness among both immigrant and native caregivers is a sign of becoming culturally competent, which helps one to recognize and avoid discrimination and stereotyping (Papadopoulos et al., 1998). Cultural awareness, cultural knowledge, cultural skill, cultural engagement and cultural desire are the crucial considerations in developing cultural competence (Campinha-Bacote, 2002; Xiu, 2009).

International law on cultural human rights states that every human being has the right to culture (Mirabelle, 2013). However, cultural and religious rights cannot be invoked only to justify the rejection or violation of other human rights (Ayton-Shenke, 1995). The right to freedom of religion or belief is a fundamental human right recognized in all the major human rights treaties. Article 18 of the Universal Declaration of Human Rights (UDHR, 1948), Article 18(1) of the International Covenant on Civil and Political Rights 1966 (ICCPR) and Article 9(1) of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (ECHR) all guarantee freedom of thought, conscience and religion. These rights include the right to the development and enjoyment of one's cultural life and identity.

In Western cultures certain values may make it problematic for some Muslim workers to provide care services (Siddiqui, 2012). Indeed, it is important to understand how caregivers' culture is embedded in their professional life. For Muslim caregivers in this study, cultural competence entails knowing one's own cultural and religious values and how they are interpreted in the effort to achieve respectful and reflective collaboration in cross-cultural contexts (see Johnston, no date).

Research processes and method

In this study, I adopted a qualitative approach, which serves best when the objective is to understand experiences (Silverman, 2017) and establish clear links with research objectives (Thomas, 2006). The data were collected by telephone

in April and May 2022 through semi-structured interviews (Galletta, 2013) with predetermined themes, which are mentioned below. The themes were then modified and augmented based on their relevance to the interview (Ruotsalainen et al., 2020). The 21 informants are from six different areas in Finland and are originally from Kenya, Somalia, Pakistan, Iraq, Bangladesh and Finland. They include a Muslim immigrant doctor, public health and practical nurses, nurse's assistants, as well as non-Muslim immigrant and native Finnish nurses and a ward manager. Some are students but have work experience as interns or under an apprenticeship contract.

To find enough Muslim informants, I used my own network and asked people from a range of Facebook groups. The participation of four respondents was secured through Facebook groups and 17 were contacted through my networks using the snowball method (Kumar, 1996). The informants ranged in age from 22 to 52 years; all were female. Of the 21, six have a permanent work contract, three have worked on a short-term basis and the rest are working on temporary contracts. Not all have professional qualifications, but they all have completed a one- or two-year language course. The names used below are pseudonyms to ensure anonymity.

The semi-structured interviews included open questions on specific themes directly or indirectly connected to the research aims. The interviews were between 40 and 90 minutes in length and tape-recorded with permission from the informants. The languages used in the interview were Finnish, English and Bengali. The recorded interviews were transcribed by the author and analysed thematically. Themes pertaining to religious and cultural values and practices that matter in the work environment spanned age, ethnicity, qualifications, obstacles and the interviewee's expectations. Non-Muslim and Finnish nurses' perceptions were noted in order to ascertain their cultural competence and to discern some of the issues pertinent to the experiences of Muslim colleagues.

The main questions were: What religious and cultural issues pose challenges to both Muslim and non-Muslim immigrant workers? What kind of discrimination do they face? A summary of the aim of the study was sent to the informants by Messenger and posted in Facebook. The informants gave their verbal consent prior to the interviews, as the interviews were conducted by telephone. This study used the research approach put forward by Kankam (2020), shown in Table 7.1, informed by cultural competence theory.

Research findings and analysis

This section describes cultural and religious values and possible implications for elderly care based on the experiences of 15 Muslim immigrants, two non-Muslim immigrants and four native Finnish (one Muslim) care professionals.

Self-respect, strong motivation and language skills are important

According to the 21 informants (Muslim as well as non-Muslim), jobs are always available in elderly care. Of the 21, 12 mentioned that it is possible

Table 7.1 List of interviewees.

Name and age	*Selection criterion (Muslim, non-Muslim)*	*Degree/contract*	*Difficulties, challenges and expectations*
Farhana, 34	Finnish Muslim	Apprenticeship contract	Language barrier (LB), awareness of rights, better salary (BS)
Ripa, 42	Muslim	No degree, practical nurse (PN) assistant	Gender preferences (GP), friendly environment (FE), respect for culture (RC)
Rubina, 45	Muslim	No degree, PN assistant	LB, GP, FE, RC
Nadia 42	Muslim	PN assistant	LB, GP, RC
Omi, 32	Muslim	Student, apprenticeship contract	LB, GP, work pressure (WP), RC
Shorna, 37	Muslim	Doctor	LB, lack of self-respect, strong motivation
Lana, 41	Muslim	PN, permanent contract	LB, GP, RC, BS
Johora 41	Muslim	PN, permanent contract	LB, GP, WP, BS, RC
Jhumur, 43	Muslim	PN	LB, GP, RC
Vb	Muslim	PN	LB, GP, WP, BS, RC
Akhi, 31	Muslim	RN, permanent	LB, GP, RC, BS
Kaniz, 29	Muslim	PN	LB, GP, WP, BS, RC, FE
Shimul, 35	Non-Muslim	PN student	Language barrier, GP
Amani, 22	Muslim	PN and HN (student) short contract	WP, BS, multicultural education should be included
Fatima, 33	Muslim	PN and apprenticeship contract	LB,GP, WP, RC
Nidal, 42	Muslim	No degree, PN assistant	GP, FE, RC
Ruhi, 37	Muslim	PN, permanent contract	LB, GP, FE
Helena, 51	Finnish non-Muslim	PN, permanent	LB, strong motivation (three PNs made same type of comments)
Moon, 52	Non-Muslim	WM permanent	LB, strong motivation
Total 21			

HN, health nurse; PN, practical nurse; RN, registered nurse; WM, ward manager.

for immigrants to get a job as a practical nurse (PN) even with poor language skills. Jhumur, aged 43, a PN who had a two-year degree, was motivated to come into the care sector. She stated:

> Caring is the main idea which inspired me to take this job. Day care is mainly full of Finnish workers, and requires excellent language skills. There is less work pressure compared to work in elderly care. It is easy for foreigners to get a job in elderly care even with poor language skills. Finns do not want to work in the sector.

Problems with language skills and language barriers were mentioned by several other informants. Ruhi, 37, also a PN, said that "… in some places

foreigners aren't very welcome. This may be due to language barriers or some negative assumptions about foreigners". Shorna, 37, a Muslim immigrant doctor who completed her medical degree in another European country, made the following comment on immigrant caregivers in general:

> Self-respect and motivation are important for quality work. We have to make our position clear in terms of religion and culture, love the work and remain aware of our responsibilities. For the most part, immigrants cannot get the real message across because of language barriers.

Moon, a 52-year-old non-Muslim Asian immigrant working as a ward manager, expressed a similar view. Amani, 22, who was born in Finland, said she had strong motivation to go into the care field and was influenced by her family. Her father is a doctor, her mother a PN (Fin. *lähihoitaja*), and her sister a registered nurse (Fin. *sairaanhoitaja*).

Lana, 41, a PN, herself an immigrant accused immigrants of complaining and not following the rules:

> Immigrants (both Muslim and non-Muslim) are not experts in the work, unlike Finns. Finnish workers must adhere to the professional norms, rules and regulations; most foreign workers do not. But most of the immigrant workers do not follow the rules strictly; for example, they may not come to work on time.

Although linguistic barriers may pose challenges to immigrant caregivers, there are, as Mirabelle puts it, "other issues including values, norms, religious and health-related beliefs, gender issues in care, misjudgements, prejudice, and misunderstandings as a result of linguistic difficulties, racist tendencies and static cultural beliefs" (Mirabelle, 2013: 49). I will now turn to some of the issues that emerged in the case of my informants.

Care work treated as pious work

While for many Muslim care professionals religious practices govern numerous aspects of their lives, there are also many who follow Western customs and do not adhere to strictly Islamic rules. Notwithstanding, there are common religious issues and other considerations which arise in elderly care environments where Muslims work. The common features found in all countries and regions represent the core of Islamic culture, and the differences represent the basic features of Muslim cultures (Philips, 2007; Rassool, 2015: 13).

With regard to the demands of care work, Shimul, a 35-year-old non-Muslim Asian immigrant student, had the following comment:

> Many foreigners are coming to the care field; this is an area where you can do real care (Bengali: *Sheba*) work. If you would like to do something pious, this work will enable you to do so.

In an Asian context, Sheba means work or service thinking of the well-being of people, the belief being that by taking care of people with no consideration of salary or material issues one can open a path to heaven.

According to Diaz, giving care or caring for any living being is treated as an act of worship in Islam. Furthermore, it is commonly held by Muslims that Allah will give a great reward to and be with Muslims who fulfil their obligation of caring for those in need, including family, orphans, the physically and mentally ill, the poor and the oppressed (Diaz, 2020). The principle of Islamic care is basically shaped by religious laws, beliefs and practices (Bensaid & Grine, 2014), which may become susceptible to modification and reinterpretation (Asad, 2009). In Islamic tradition, elderly care is a religious practice that aims to maintain a good relationship by respecting God; this has a moralizing effect on the community and intergenerational relations (Ahmad & Khan, 2016; Bensaid & Grine, 2014). Islamic culture and tradition can be understood "as changeable and contextual, not homogeneous and static" (Ismail, 2021: 220). For both Muslim and non-Muslim immigrant caregivers, care work is considered pious work.

Discussions on Islam and Muslim identity illustrate that religion and culture are practised in different ways in different contexts (Enstedt, 2023). The foundation of Islam comprises five pillars: faith (Shahada), prayer (Salah), charities for the deprived (Zakat), fasting (Sawm) for self-purification and a pilgrimage to Mecca (Hajj) (Lovering, 2008; Sahih Muslim 8). However, Muslim people are not a homogeneous group. Though Muslims share the same religious values and practices, the behaviour of different groups of Muslims is often shaped by cultural practices that may not be in agreement with basic religious practices (Enstedt, 2023; Rassool, 2015).

Religion, country of origin and skin colour are causes of discrimination and racism

A pleasant working environment contributes to reducing discrimination against both Muslim and non-Muslim caregivers. Seventeen of the immigrants had experienced discrimination in the workplace to some degree. In this regard Fatima, 33, a PN, noted:

> When working in a hospital, in a team, we need to first determine who will go where and how we will share the work. There was one colleague who never talked to me. She should say something like "You go there, I will go here" and so forth. She talked with others and did not treat other people this way.

In the beginning, immigrant workers face different difficulties in homecare visits than they do in nursing homes. In this regard Fatima said, "I speak fluent Finnish. I talked on the phone with clients and they did not realise I was not a Finn. From their facial expression … it was clear that they did not expect anybody like me".

Farhana, 34, who has a Finnish background but converted to Islam, commented on the awareness of immigrant workers' rights and discriminatory attitudes of care receivers: "Clients were disappointed when they heard what my religion was; immigrants should be aware of their rights, which would help to reduce discrimination".

Ripa, 42, for her part, who worked as a nurse's assistant and holds strong Islamic values, noted the following: "Some older people did not like me because I am Muslim. … it hurts when my colleagues don't want to talk to me".

Religion and skin colour influence (Nayel, 2017: 128–129) the attitude of caretakers as well as colleagues. Shimul shared her own and fellow students' experiences, commenting:

> My friend said that on a home visit some clients refused to accept services from a foreign worker. Skin colour and religion matter. Those who come from Europe (Russia, Estonia) adjust faster than we do; clients also prefer them. As an Asian, we have many things to learn compared to Europeans.

In Ripa's workplace, there were other Muslims from different countries, not all of whom covered their hair, and they discussed a specific male client whose attitude towards Muslims was not good. She said:

> It is okay for me that I cannot change their attitude; they are over 80, but it is upsetting when I see some of our Finnish colleagues looking at me differently because of my hijab.

About the negative attitude of one of her Finnish colleagues, she shared the following:

> One day I had to leave work to go to a course that was part of my studies; a second shift worker came who was Finnish. She suddenly became angry, saying I was not a responsible worker … She shouted and another young Finnish colleague felt her behaviour was strange and suggested I talk with my boss. I had a talk with my boss and the next day the worker apologised. So not all individuals are the same in the workplace.

Amani, 22, a PN, does not cover her hair and did not bring up the issue of gender preferences (Muslim African background, born in Finland). She is studying to become an HN (four-year programme) and reports no direct experiences of racism.

> I do my work properly. I do not raise religious issues at work. To be honest, I don't think I have ever encountered workplace racism. We are equal in the workplace.

All immigrant informants said that people have negative images and misconceptions about immigrants, for example, that immigrants are lazy and do not want to work. However, Jhumur pointed to the positive attitude of her boss and colleagues:

> There are several of us Muslims working in this institution. She has organised a place where we can pray during our work time. We have a ten-minute break for that. If I could take care of women only, that would be good for my mental health. If I need to leave this job, having to take care of men will be the only reason.

Ten middle-aged care professionals mentioned that most of the time young and gig workers (Fin. *keikkatyöläinen*) – both immigrant and non-immigrant – spend more time on the telephone and are not committed to their work. They think that it is the permanent workers' responsibility to do a proper job with the client. In this regard, Kaniz said:

> For the most part, a gig worker called in does not follow work ethics, rules or stick to the timetable. They do not take the initiative. They should not be thinking "I am only working for one or two days, not regularly in one place".

Immigrants must work harder to reduce negative images. Fatima made the following comment:

> If you are Muslim and African, that is another minus. We (immigrants) need to work hard. If you work hard and if we educate ourselves then they will realise that we are competent. We have to give our best. Get respect in the society. You have to keep in mind that compared to Finns … you will never have the same opportunities.

To clarify, Fatima said where native Finns give a 50-per cent effort, foreigners should give 110 per cent to remove the negative image of immigrant workers. Muslims must negotiate their identity in a European migration context (Sarkar, 2012), where Muslim women are often surrounded by negative prejudices (Inge, 2017: 5). Sharna, 37, a Muslim doctor, has a contrary view. She says the main obstacle where immigrant PNs are concerned is their half-hearted attitude:

> You have to be clear about your responsibilities at work and take the initiative to do something. Some are doing no more than the work they need to do. If they don't like the work, they should leave.

Ruhi also said that "most Finns are friendly, their attitude changes towards me when they see how I work. I always try to give 100 per cent so that their assumptions about Muslim women change. Many think Muslim women stay at home or are lazy".

Studies have shown that experiences of continuous high levels of work pressure can lead to disparity, which can result in deterioration in relationships or discriminatory attitudes (Thompson, 1995). This no doubt applies in the elder care sector, where work is stressful.

Kaniz said that Finnish colleagues work with full responsibility. About unfriendly attitudes on the part of colleagues, Kaniz had the following comment:

> Finnish colleagues are the principal workers since I don't have a nursing degree yet and I am helping them. They choose their clients first and then give the other clients to me. Sometimes they give all the hard work to the part-time workers. If you do good work, it will really make a good impression in your workplace.

Three Finnish workers mentioned that lack of language proficiency, a poor understanding of work responsibilities and lack of dress codes create different kind of challenges among immigrant caregivers. One of the workers, Helena, commented on male immigrant caregivers saying that "immigrant men have problems following instructions given by women since it is not part of their culture".

Regarding distribution of work, five workers mentioned discriminatory attitudes towards immigrants. Rubina, aged 45, who has been working as a nurse's assistant, said:

> In my first working place, the difficult tasks were always given to me and us foreigners … Ethiopians and Somalians had to do all the hard work.

According to them, most of the time Finns are taking relaxed attitude towards work, for example, drinking coffee. Many times, they are laughing at the immigrant workers.

Johora, 41, who came to Finland from Africa in the 1990s stated:

> Earlier, nursing work was easier; the situation was much better. The work is now harder because there are more frail older people, fewer workers and the salaries are low.

Shimul also mentions the same issues concerning work pressure and salary:

> There is a shortage of caregivers. Because of the low salary and work pressure, native Finns and men have less interest in working in this sector. Only those who love this profession are doing the work seriously.

Amani contributed the following suggestion:

> Foreigners should get involved in hobbies after work to become integrated in Finish culture, to develop language skills. Filipinos are rather

> cheap, working longer hours. They are very tired since they work 8am to 8pm. They are receiving less salary, but are still so grateful.

Although many immigrants may be highly qualified in their country of origin, immigrant caregivers have found it is difficult to get their qualifications officially recognized (Vartiainen et al., 2016) and working as assistant nurses with lower pay. Some, however, work although they have no nursing education. As a result, the work might not meet the standard of work desired.

Gender preferences, dress codes and privacy- and modesty-related issues matter

Islamic values in the care sector have been discussed only with reference to Muslim patients' modesty and privacy (Padela & Rodriguez del Pozo, 2011). These also merit careful consideration in the case of Muslim care professionals. Previous research suggests that a female Muslim client should always be taken care of by a female staff member (Al-Shahri & Al-Khenaizan, 2005). The same practice (female staff and client) could be applied where Muslim care professionals are concerned (see Rassool, 2015). However, this is not to say that all Muslims, female or male, share the same view on this matter. In this study, all immigrant informants talked about feeling somewhat uncomfortable when changing men's diapers and washing male clients. Interestingly, Fatima ascribes her religion (Islam) a conservative character in contrast to medical issues or care:

> At first, I was feeling uncomfortable … We have to look at the clients like our grandparents or children. I know our religion is conservative, but when it comes to medical issues or care, we have to put these views aside. If we choose not to do this or that, then who is going to do it?

Nadia, 42, with a qualification as a nurse's assistant, said: "I am Arabian. Older people are nice to me. I am helping them from my heart. I see them as a father or mother, but feel odd when I need to change a man's diaper".

However, taking care of an older man was not a big issue for one young Muslim worker, Amani, who said: "Religiously, my parents said that I can take care of a man … I feel like I keep my professional identity on at work; I keep my religion private. I practice religion at home". Hence, it may be difficult to locate the unease for some of the female caregivers when it comes to taking care of men. Is it their religion or cultural background?

Willingness and working in one's comfort zone are connected to the well-being of care professionals. Islamic beliefs and values are often misunderstood (Rassool, 2015, 2019) and misinterpreted by westerners, a fact mentioned by some of the informants.

According to Pervez, in Islam, both men and women should dress modestly, uphold a moral social order and maintain self-respect (Pervez, 2018).

Muslim women should, as Hammoud (et al.) puts it, be dressed such "that clothes are neither transparent nor figure-revealing and that hair, arms and legs are covered, especially in the presence of any adult male" (Hammoud et al., 2005). The use of the hijab often subjects the wearer to bias (Siddiqui, 2012). Joly, 41, encountered negative attitudes when wearing the hijab:

> My colleague asked why I was wearing a hijab, saying that I looked much prettier without it. I said that my culture and religion do not allow me to wash men. I was only feeding male clients and making their beds. But some of the colleagues did not allow this.

Regarding gender preferences in healthcare encounters, Ripa observed the following:

> In my previous workplace, there were 11 Romani women on the ground floor, with the instruction that only women caregivers could go take care of them. So why is there no such provision for Muslim caregivers who want men to take care of men, and women to take care of women?

According to Al-Shahri and Al-Khenaizan (2005) Islamic practices, such as a female avoiding eye contact with a male (Al-Shahri & Al-Khenaizan, 2005) and avoiding shaking hands with the opposite sex – which is forbidden (Abdul Aziz al-Musnad, 1996) – should not be misinterpreted. This is one of many interpretations of Islam, often far from how Islam is practised and interpreted around the globe. However, these might cause complications for many Muslim care professionals who cover their hair and thus encounter negative attitudes in Western countries (Begum & Seppänen, 2017; Haldenby, 2007). Evidence suggests that in some cases job applicants in Finland and Norway were rejected after they disclosed their religious practices (Begum et al., 2021; Laurén & Wrede, 2008).

Akhi, 31 who use a hijab, shared this experience during her internship in an eye clinic:

> One older man client said "I do not want her to take care of me". My supervisor told me that I should accept it as normal and not let it upset me."

Akhi, who wore her own hijab as opposed to one issued by the hospital as approved hospital clothing, went on to say:

> There are multicultural people coming into the healthcare professions. Care facilities should set aside hijabs for workers who want to wear them. It is their cultural right.

Health professionals suggested discussed that there should be some options in this regard to avoid complications so that they don't need separate arrangements to get permission when it comes to questions of hygiene.

Omi, 32, had a Finnish degree, but in another field, and was brought up in Finland. She is a devout Muslim and considered situational awareness and cultural sensitivity important. She commented:

> My identity: I am Muslim, although Finnish in terms of heritage and cultural upbringing. The hijab is part of me. If you do not allow me to wear it, then I will not work. My moral ethics and behaviour are the main issues. …. I have to do everything just right to gain the trust of clients. I did not bring up the question of my praying at work. We have more in common than we have differences.

Regarding the hijab, Fatima noted:

> I wear hijab like a turban. Both my colleagues and clients showed positive interest in it … my sister-in law faced problems in the hospital for hygienic reasons.

Although there are many stigmas regarding the hijab, the attitude towards Fatima was positive. Within Islam, attention generally focuses on religious practices, dress codes, dietary rules and veiling becomes important (Enstedt, 2023).

Praying, fasting, dietary considerations and family culture issues matter

Praying five times a day (Salat) is one of the main practices for Muslims. To pray properly requires clean clothing as well as a quiet and clean place. Care professionals working morning, day or night shifts go through a minimum of two or three prayer times (depending on summer or winter time) during their working day. Some Muslim caregivers may want to pray in the workplace, and it is important to do so at the prescribed time. Jolly prayed in the changing room, mentioning the positive attitude of her boss, who said, "You can pray in the computer room if there are people in the changing room".

Ruhi, 37, also talked about praying at work:

> I go to pray whenever I want and can find the perfect time. But I sometimes feel guilty going to pray during busy hours … it would be great if there were a clean, empty room for prayers.

Another core practice which Muslim caregivers have to observe at work is fasting during the month of Ramadan (Begum & Seppänen, 2017). They had both positive and negative experiences where Ramadan and religious festivals were concerned. Fatima had to explain to her boss that she had to be put on the morning shift because of fasting and happily reported:

> She took my religion into consideration and put me on the morning shift for the next three weeks. Now she gives me almost three days off each week. I was the first Muslim to work in this care home.

According to scripture, Muslims must avoid eating pork or drinking alcohol unless these are life-saving remedies and no substitute is available. Five caregivers who hold Islamic values strongly expressed uncomfortable feelings when required to serve non-Muslim food to clients.

Ruhi stated that "serving a haram food item, for example pork, makes me feel uncomfortable. Some workers can be hired to serve non-Muslim food/help to feed elderly clients".

Kaniz did not want to serve a certain food during her training period experiences:

> I did not want to touch those foods which are not allowed in my religion. Although my supervisor took care of male clients I had to serve food which I did not want to serve.

According to Hammoud et al., traditional Islamic practice upholds a conservative approach whereby, for example, touching even elderly non-relative males is not allowed (Hammoud et al., 2005). In some families with children, the husband is not allowed to or should avoid working evening or night shifts. Although "Islam" and "Muslim" are compromises in different contexts (Enstedt, 2023), the family culture in Islam has significant influence on many Muslims who are living in Western cultures. Muslim leaders differ and do not always share the same views. According to Nayer Taheri (2009), in Western countries, Muslim leaders have adopted a range of local practices and improvised where these have not conflicted with Islamic Law.

Working a night shift was an obstacle mentioned by 15 of the Muslim caregivers. For both native and immigrant nurses, shift work (day shift-night shift) matters if one has a family and children. In this connection Kaniz said:

> During my studies … I worked only weekends. The night shift is a problem for me. I have a small daughter. Also, my husband does not want me working the night shift. The night shift is good for those who do not have a family or whose children are grown.

Akhi noted the following:

> In the hospital ward, we work in three shifts. I can easily change shifts with other foreigners during our Muslim Eid. The Finns do not want to change since our holidays are not public, and they do not get extra money for working then.

The perception of many Muslim migrant care professionals is connected with other people (one's own group) and family. As Enstedt (2023) has noted, contemporary society is far more fluid, in a state of change, than previous societies, and is being negotiated.

Conclusions and recommendations

From the above discussion, it can be said that all caregivers should act professionally in a culturally diverse work environment; at the same time, caregivers need to increase their mutual understanding to respect the cultural and religious values that those in the workplace hold. Everybody should endeavour to refrain from doing things that might undermine the cultural and religious right of others. Both immigrant and non-immigrant caregivers need training to become more culturally competent.

According to the informants in the present study, elderly care is not an inherently desirable job. Although Muslim care professionals know the type of work they need to do, they experience a cultural and religious rigidity at work when performing their profession. One can see a lack of motivation among the informants to work in this care sector. Yet, it is a field where immigrants get jobs easily; there is no need to speak Finnish perfectly, especially in the case of practical nursing.

Not all Muslim women adhere to religious values in work in the same manner or to the same degree. That was made explicit when it came to taking care of older men, where uncomfortable feelings were a very common issue identified by all informants. There are some noteworthy differences between the young and older Muslim caregivers regarding taking care of male clients. While some young Muslim nurses distinguish between their professional role at work and their religious identity, which enables them to carry out their tasks, others struggle when required to take care of older men. Some of the informants had a negative impression of some of the permanent staff, who were not seen as being serious about their work and gave hard tasks to immigrant workers when distributing work within teams.

Most informants experienced racism to some degree and challenges in their work environments. Interestingly, by contrast, immigrant informants mentioned mostly positive attitudes on the part of their bosses. Lack of language proficiency is one of the main reasons why immigrants were discriminated against in the workplaces. Some informants faced racism because of their country of origin, skin colour and use of the hijab. Wearing a hijab, a long dress, finding times and clean places for prayers were cited as challenges for many of the Muslim caregivers interviewed. These findings can help to ease workplace challenges for immigrants in Nordic communities, which are witnessing a growing diversity in cultures and religions.

Surprisingly, some of the immigrant informants' (both Muslim and non-Muslim) statements indicated that immigrant workers are not following rules and regulations properly, an observation supported in Finnish workers' comments. Some of the informants believe that one of the reasons for this shortcoming is the language barrier; others consider it negligence. Significantly, given that the number of Muslim immigrants in this field will most likely increase, the study gives rise to some recommendations which policymakers,

care mangers and care professionals should consider to enable newcomers at work to follow and understand professional ethics. The three suggestions are based on the informants' expectations and the author's own reflections after conducting this study.

Firstly, when recruiting staff, management leaders should always – no matter from where the person seeking the position originates, be careful to explain the work responsibilities so that they know what they are expected to do and can perform those adequately.

Secondly, education on different religion and cultural values and training programmes on intercultural communication should be included starting in day care and continue to elderly care. Also salient would be awareness-raising courses on discrimination and racism in healthcare.

Lastly, some changes could be made in care practices in a multicultural environment. For example, if male caregivers or Finnish caregivers were to take care of male clients and Muslim women were to take care of women only, this would promote better services for the elderly in care institutions and hospitals.

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