

MIGRANT WORKERS' PERCEPTIONS, EXPECTATIONS AND
EXPERIENCES OF OCCUPATIONAL HEALTH SERVICES IN FINLAND

LEONARD ODHIAMBO APONDI

MASTER'S THESIS

UNIVERSITY OF TAMPERE

SCHOOL OF HEALTH SCIENCES

(PUBLIC HEALTH)

MAY 2015

ABSTRACT

UNIVERSITY OF TAMPERE
School of Health Sciences

APONDI, LEONARD ODHIAMBO: Migrant Workers' Perceptions, Expectations and Experiences of Occupational Health Services in Finland

Master's Thesis, pages 62, appendix 2
Supervisors: Pirjo Lindfors, PhD, Docent
Hanna Rautajoki, PhD
Health Sciences (Public Health)
May 2015

The northward rising trend in the number of international migrants has resulted to unprecedented implications on healthcare sector. Events accompanying migration have impact on both the migrant population and the hosting community. To understand the challenges encountered by the migrant workers in the host country, it is imperative to explore their encounters with the services by listening to the lived experiences.

The aim of this study was to bring out immigrant workers' expectations and experiences of occupational health services in Finland. The study explored the expectations and lived experiences of the migrant workers.

A qualitative research method was used for this study. The study population consisted of 12 participants who were sampled purposively. Data was collected through face-to-face interviews. The data was analyzed by thematic content analysis method.

The results of the study identified barriers to occupational health services to include language and communication, difficulties arising from navigation through the Finnish healthcare system and issues related to cultural differences. The study also identified workplace safety as being associated to migration and health.

In conclusion, the study recognized the process of healthcare access by the migrant worker as being multidimensional. Therefore, the study recommends for enhanced collaborative approach by employers, employees and other relevant stakeholders. The efforts invested towards strengthening health providers' relationship with care seekers would go a long way in improving occupational health service access.

Contents

1	INTRODUCTION.....	1
2	LITERATURE REVIEW.....	5
2.1	Overview of the studies	5
2.2	Migrants' health in the host country	6
2.3	Patterns of healthcare access and utilization among the migrant population	8
2.4	Tracing the origin of occupational health services	10
2.5	Benefits of occupational health services	12
2.6	International perspective on occupational health services	14
2.7	Organization and provision of occupational health services in Finland.....	16
2.8	Occupational health services access and usage by migrant workers.....	17
2.9	Factors facilitating healthcare access	19
2.10	Structural factors that promote or inhibit healthcare access	20
	RESEARCH PURPOSE, RESEARCH QUESTIONS, AIMS AND RATIONALE	23
3	RESEARCH METHODOLOGY.....	24
3.1	Study Design.....	24
3.2	Sampling.....	24
3.3	Data collection.....	25
3.4	Data Analysis.....	26
3.5	Ethical considerations and informed consent	26
4	RESULTS.....	28
4.1	Participants' background information	28
4.2	Migrant worker's perceptions of OHSs.....	28
4.3	Expectations of OHSs.....	29
4.4	Determinants of OHSs experiences	30
5.4.1	Friendliness and professionalism in service delivery.....	30
5.4.2	Continuity and coordination in the care continuum	31
5.4.3	Physical accessibility of OHSs provision units.....	32
5.4	Factors contributing to unmet expectations	33
5.4.1	Inaccessibility to health related information	33
5.4.2	Lack of language skills as a communication barrier	35
5.4.3	Use of translators as communication facilitators	36
5.4.4	Ability to navigate through the health system.....	37
5.4.5	Preference for linguistic and culturally competent providers	38

5.5. Participant’s health related concerns arising from work environment.....	40
5.5.1 Lack of social support, impediment to workers’ wellbeing.....	40
5.5.2 Health education and periodic health check-ups.....	41
5.5.3 Pre-employment medical examination as a compulsory requirement	42
5 DISCUSSION	44
5.1 Study strengths and limitations.....	50
5.2 Conclusion and recommendations.....	52
6 REFERENCES.....	54
APPENDICES	

ACKNOWLEDGEMENT

I would like to express my sincere gratitude to all immigrant workers in the city of Tampere who participated in this study. Without your valuable participation, the study would not have been successful. It was a great honour and privilege to listen to you sharing your lived experiences of occupational health services in Finland. I do extend my sincere appreciations to the organizers of recreational activities in Tampere city especially the African Football Association. In addition to other forums, the football matches organized during the summer period provided the opportune chance to interact with migrant workers, arrange, and even conduct face-to-face interviews. In addition, I do appreciate the support of other friends, colleagues and fellow students. Your advice, critic and support played an important role in the entire research process.

I greatly appreciate the worthy support given to me by my supervisors, Docent Pirjo Lindfors and Dr. Hanna Rautajoki. Your valuable advice and guidance enabled be to wade through the entire research process with confidence. In addition, I wish appreciate the technical support I received from the Information Technology department especially Tertio library staff members. This work would not have been complete without that precious technical advice I received from you, precisely on information search process.

To my family members, receive my sincere appreciations for your continuous prayers, patience, moral and material support. Many years have passed since I embarked on this long and tedious journey to pursue my education ambition in Finland. I would never have accomplished this mission without your constant prayers, encouragement and support. Above all, I return all glory and honour to the Almighty God who has enabled me to achieve my childhood dream, education.

LIST OF ABBREVIATIONS

EU	European Union
CSDH	Commission on Social Determinants of Health
ILO	International Labour Organization
IOM	International Organization for Migration
OH	Occupational Health
OHSs	Occupational Health Services
OECD	Organization for Economic Cooperation and Development
WHO	World Health Organization

1 INTRODUCTION

Globally, there are 232 million international migrants (OECD 2013) of which 60% reside in developed countries. The reported northward trend in the number of international migrants in the past few decades is projected to continue and even to escalate further in the near future. Today, the number of workers is estimated to constitute half of the world's population (WHO 2007). The population of workers outside the native country stands at 105 million and the numbers are projected to continue rising in scale and complexity in the coming years (IOM 2011). The events associated with migration are non-negligible considering the challenges they pose to both migrant population and the host country.

By the end of 2013, it is estimated that Finland was already hosting 301, 523 immigrants (Statistics Finland, 2014). This number represented 5.5% of the Finnish total population. The immigration pattern in the Finnish population is noted to have sharply increased in the past two decades. It is reported that there were only about 120,000 immigrants in Finland by the year 2003. This indicates that the number of immigrants in Finland has over doubled in the last one decade.

The surging numbers of international migrants has been attributed to the modified patterns in globalization and industrialization. At the same time, natural and manmade factors such as regional conflicts, wars, persecutions, natural disasters, and family reunions and even in search of better socioeconomic prospects have actively accelerated migration activities. It is worth noticing that these changes have not come without challenges both to the migrating population and the hosting countries (WHO, 2010).

In Finland, Health Act 2010 stipulates that, access to healthcare services is a right to every resident. However, considering the complexities accompanying migration, administration of occupational health services to the migrant workers has never been smooth without hitches.

Past studies have enumerated various difficulties encountered in the process of providing culturally sensitive healthcare services (Raso, 2006; Teng, Blackmore, & Stewart, 2007). The challenges experienced are reported to spread across health systems in both developed and developing nations. Partly, this is due to the diverse characteristics of the migrant population and the prevailing re-structuring of governmental policies (Chung, 2010). Therefore, the access and utilization process of healthcare services by the migrant population is susceptible to difficulties yielding to negative health experiences (Akhavan, 2012; Renzaho & Oldroyd, 2014). In order to assess the access and usage of healthcare services by migrant population, it is prudent to bring out their experiences of the services. The voice of the minority population is considered to be valuable and irreplaceable in understanding service users' experiences (Clarke, 2011).

Additionally, it is postulated that structural inequalities in healthcare systems impede access and utilization of the services (Renzaho & Oldroyd, 2014). Such inequalities would range from cultural gender roles, discrimination, and exposure to health information and participation in the formulation of health policies. The changing economic times has brought with it special demands and changes in health policies. It is recorded that such changes have had far reaching implications to the users of healthcare services. Lately, Europe in general continue to experience economic and social crisis (Escolar-Pujolar, Bacigalupe, & San Sebastian, 2014). The impact of such economic changes has been observed to escalate the already precarious health conditions. This has in turn affected various social groups within different societies. The vulnerable groups predisposed to

these effects include young people, immigrants and ethnic minorities. In addition, reduction in funding for health care sector, privatization of primary and specialized health services has perpetuated unfavorable health conditions for the migrant population.

The effects of these changes have been associated to long waiting time and introduction of co-payments in some healthcare systems (Daniel, 2010; Devilla et al., 2011; Laamanen, Simonsen-Rehn, Suominen, & Brommels, 2010). Therefore, the ever growing need for culturally sensitive services would no longer be neglected (Clarke, 2005; Verbeek et al., 2001). It is also postulated that, effective systems with the potential to equip public health personnel with multicultural skills and knowledge would act as an imperative measure to mitigate the resultant effects of global health reforms (Schenker 2010).

Past studies done to assess the access and usage of occupational health services by migrant workers have elicited various difficulties and barriers encountered in the process (Leong & Mak, 2014; P. M. Smith & Mustard, 2010; Wafula & Snipes, 2014). However, past records reveal minimal studies done in Finland to assess the experiences of immigrant workers in regard to accessing occupational health services. Recently, Castaneda, Rask, Koponen, Mölsä, and Koskinen (2012) conducted a quantitative study to explore the concept of work and health among Russians, Kurdish and Somalis in Finland. The results of the study indicated that migrants had lower access to OH care in comparison to the native-born population. (Castaneda, 2012)

Therefore, the purpose of this study is to explore occupational health services access and utilization among immigrant workers in Finland. The aim of the study is to bring out immigrant workers' expectations and experiences of occupational health services in their own voices. The study intends (1) to bring out the lived experiences of immigrant workers

as the consumers of occupational health services (2) to understand the challenges they encounter in the process of acquiring the services (3) to bring out their suggestions to improve the services.

2 LITERATURE REVIEW

2.1 Overview of the studies

In the recent past, the concept of accessibility in health services has gained popularity among scholars. Aday and Andersen (1973), studying the concept of access, identified various components involved in the process of accessibility. The components of access included the physical accessibility, availability, accommodation, acceptability and affordability of the services. According to the original conceptual framework, the individual determinants dictating the use of the services include predisposing characteristics (age, sex, ethnicity), the enabling characteristics, equated to one's capacity to use the healthcare services in regard to family and community's income. The aspect of resources is linked to the availability of health personnel and distribution of health facilities. Lastly, the final component of access is associated to the need of the services as characterized by the perception and evaluation of ill health (Blais & Maiga, 1999)

In healthcare provision, policies governing administration of services is identified as the gateway to healthcare access. Health policy has the potential to influence human resource allocation, capital and entire structure of the healthcare system. Therefore, the composition of healthcare users and their usage patterns would be dictated by health policies and the structure of healthcare systems (McFall & Yoder, 2012; Norris & Aiken, 2006). Ultimately, the effect of unequal healthcare access pose challenges to both utilization process and satisfaction levels of the service users.

The ability of OHSs consumers to access and use the services, just like other primary healthcare services, is dependent upon the characteristics of individual users and system organization of health institutions. Owing to the unique characteristics of the migrant population, foreign workers and their families are considered to be more vulnerable to reduced healthcare access in the host country (Morrison, 1995). The reasons surrounding the unequal healthcare access are associated to variation in socioeconomic status and unfamiliarity with the health system. Therefore, the identified reasons remain to be major impediment towards healthcare access with the potential to impact negatively on health outcomes of migrant workers and their families.

2.2 Migrants' health in the host country

WHO Commission on Social Determinants of Health identified the existence of health inequality as being associated to individual's social class, gender and ethnicity (CSDH, 2008). The United Nations also recognized the uniqueness of migrant workers in the "International Convention of the Protection of the Rights of all Migrant Workers and Members of their Families" (United Nations, 1990). The document stipulated minimum human right conditions to be met by member countries, which included equal access to healthcare services. In addition, the migrant workers are considered to be more predisposed to occupational health risks in their work places in comparison to the native-born population (Ennis, 2015).

However, the results of past studies conducted to assess the health status of migrant population in the host country elicit mixed results. Considering the healthy immigrant effect, the newly migrated persons tend to present with better health status than the native-born population (Wingate & Alexander, 2006). This is attributed to the fact that

those who migrate tend to consist of the middle class in their native countries. Therefore, they tend to have better socioeconomic status in comparison to their counterparts who remain in the emigration country. The superior health status of the newly migrated persons is also attributed to rigorous selection process in the emigration country. At the same time, strict screening regulations in the receiving country is attributed to the healthy immigrant effect (Dean & Wilson, 2010).

It has also been documented that, gradually the health status of the immigrant population deteriorates to the same level and even below that of the native-born population. The deterioration in the immigrants' health status is partly associated to limited healthcare access and also to the acculturation effect in the host country (Dean & Wilson, 2010; Harrington, Wilson, Bell, Muhajarine, & Ruthart, 2012). Similarly, it is argued that health characteristic of the migrant population is basically influenced by the prevailing environmental conditions in their places of origin, the transition process to their new destinations and the existing conditions in their new settling environments (Gushulak & MacPherson, 2004).

The process of migration and settling even becomes more challenging in the absence of adequate preparation, lack of social support and barriers in social and healthcare access (Virupaksha, Kumar, & Nirmala, 2014). Additionally, migrant population is reported to face insecure situations resulting from non-availability of their own community members hence, increased vulnerability to mental illnesses (Virupaksha et al., 2014). The noted upheavals in the migration process have also been associated to poor health outcome among the migrant population. Virupaksha and colleagues (2014) pointed out the vital contributions that could be achieved by making the services more inclusive and culturally sensitive to the needs of the minority service users. They suggest for training and re-training of health personnel to gain advance skills in handling the increasing

cultural diversity of healthcare consumers. They argued that such efforts would reduce the hurdles impeding healthcare access and hence, promote health equity.

On the other hand, migrants who experience downward mobility or underemployment in the receiving country, are also vulnerable to suffer mental health complications (Das-Munshi, Leavey, Stansfeld, & Prince, 2012; Rask et al., 2015). Supporting the argument, Das-Munshi and co-workers (2012) meta-analysis results concluded that, immigrants who move to higher income countries but experience downward mobility or underemployment experience mental health disorders.

2.3 Patterns of healthcare access and utilization among the migrant population

The concept of service access and utilization is an integral part when considering health equity. Factors that determine healthcare seeking behaviors are dynamic and multifaceted. Studies have pointed out that consumers' expectations of the services are built on how they perceive the services and their views on the providers of the services. This in turn determine their attitude and interaction with the services hence, define the utilization pattern (Cortis, 2000; Malin & Gissler, 2009)

Daniel (2010) posits, poor health outcome could be one of the resultant effects of reduced healthcare access. Therefore, concerted efforts of the healthcare providers and other collaborators would significantly contribute towards reducing the disparities by improving healthcare access. Creativity of healthcare provider advances advocacy, which in turn enhances effective implementation of health policies.

Similarly, Nelson (2002) argues, realization of better health outcomes would be achieved through modification of strategies tackling health system policies that articulate equitable healthcare access. Such health policies promote community empowerment approaches by reducing linguistic barriers and championing consumer participation. The involvement of clients in their care provides diversity to health providers' perspective of care provision thereby, advancing equality in service delivery.

However, the identified challenges that hinder the advancement of these strategies include sociocultural differences, perceived insensitivity by healthcare providers and differences in cultural values. Other challenges faced by the minority users of health services would include differences in cultural norms and practices and the perceived discrimination by the native-born service providers (Bollini, Pampallona, Wanner, & Kupelnick, 2009; Kirmayer, 2011).

Consequently, promotion of cultural competencies in healthcare service provision plays a pivotal role in reducing healthcare disparities. Resultantly, it promotes awareness of health beliefs and understanding of differences in health perceptions. It is postulated that, cultural competence among healthcare providers improves communication, interaction and contributes to better health outcomes (Peters et al., 2008) . It is also emphasized that entrenchment of the migrant population in policy formulation, implementation and even evaluation, advances the process of integration in the host country (Erdal, 2013; Long, Hylton, & Spracklen, 2014)

Asanin (2008), conducted a study in Canada to assess immigrants' accessibility to healthcare services in the Canadian health system. The results of the study identified factors such as the physical location of health provision units as an important determinant of healthcare access and usage of the services (Asanin, 2008). The study also

pointed out socioeconomic and cultural factors as contributors to variation in healthcare access between the migrants and native-born population. The identified socioeconomic and cultural differences acted as barriers to healthcare access. The study associated these effects to the reported negative health experiences among the studied population.

Another study was conducted by Priebe and co-workers (2011), which assessed the good practice of healthcare for the migrant population. The study involved the healthcare providers sampled from 16 European countries, Finland being one of the participating countries. The results of the study identified language barriers, cultural differences and difficulties in navigating through the healthcare system as some of the challenges facing migrant healthcare users. These barriers were identified to be cutting across the sampled 16 European countries. Therefore, the study proposed for organizational flexibility, provision of translation services, accessibility of health information and cultural competence among the healthcare providers. (Priebe, Sandhu, Dias et al., 2011a)

2.4 Tracing the origin of occupational health services

The origin of occupational health is traceable back to six decades ago. In 1950, World Health Organization (WHO) defined OHSs;

“Services entrusted with essentially preventive functions and responsible for advising the employer, the workers and their representatives in the undertaking of the requirements for establishing and maintaining a safe and healthy work environment which will facilitate optimal physical and mental health in relation to work and the adaptation of work to the capabilities of workers in the light of their state of physical and mental health”

According to World Health Organization (WHO, 2007), the health of workers is not only affected by their working conditions but also individual characteristics, socioeconomic status and the structure of healthcare systems. These factors are considered to contribute towards accessibility and usage of OHSs. During the Sixtieth World Health Assembly, delegates of the conference emphasized the importance of eliminating OH inequalities. The proceedings of the conference identified the variations that were existed by then within and between countries. The assembly embraced the need to strengthen the primary prevention of occupational hazards at workplace in order to promote worker's health. The assembly also realized the need to improve responsiveness of healthcare systems towards the workers' health needs.

The importance of an enhanced accessibility to OHSs was also identified as another important pillar to improve workers' health. Therefore, the assembly recommended for stepped up efforts of healthcare systems to improve general performance and promote healthcare accessibility. The core objectives of OHSs would be better achieved through increased service coverage by skilled and competent OH personnel. Training and re-training of OHS providers on occupational health hazards acts as a significant contributor in realization of workers' wellbeing. In addition, emphasis is laid on the factors that improve technical skills of OHSs providers through enhanced work place safety and healthcare access.

Basic OHSs is recommended to employers as a minimum requirement to be provided to every worker (WHO 2007). As emphasized by Kinnunen-Amoroso (2013), the main objective of OHS is to prevent illnesses related to working activities. The intended goal is to improve health and workability through disease prevention and health promotion. Therefore, making OHSs available to all workers would form the cornerstone in enhancing workability, promotion of safe working environment and contributes in

significant measure towards the achievement of workers' safety and wellbeing (Kinnunen-Amoroso, 2013)

2.5 Benefits of occupational health services

The occupational health risks and environmental hazards are known to impair work safety and may affect the functionality of working population (Kankaanpää, Suhonen, & Valtonen, 2008). The OHSs are tailored to offer guidelines to both employers and working community on health related issues and to intervene when workers' health status is being compromised. The implementation of OHSs involves interventions that identify and correct health threatening conditions affecting workability. Occupational health services also offer health education to workers, employers and policy makers on health issues contributing to healthy working life and maintenance of good health.

When implemented appropriately, OHS has the potential to contribute towards safe working conditions hence, reduce ill health at work place. (Kankaanpää et al., 2008). Working in a safe environment would translate to motivation among workers resulting to efficiency in productivity. The cost of compensating work related injuries and sickness absence has negative ramification on business operations. Reduction of the factors that propagate unhealthy work conditions mitigates illnesses at work place and reduces occupational injuries. It is also argued that investment in employees' health through OH programs contributes in curbing unnecessary absenteeism, reduction in occupational accidents and disability rates (Peltomaki et al., 2003)

The presence of illnesses among employees in work place would be associated to reduction in the cognitive ability of workers leading to occupational injuries. The active implementation of OHSs therefore, would reduce the number of industrial accidents and

even deaths related to occupational accidents. Rantanen and co-workers (2004), quoting Takala (1998), highlighted the positive results of an effective OH system. The study compared the prevailing OHS statistics between the developed and developing countries. For instance, it was reported that in USA there were 5.3/100,000 fatal deaths in the year 2000 compared to 34 in Republic of Korea and 99.7 in Burkina Faso (Rantanen, Lehtinen, & Savolainen, 2004). The variation in the figures pointed out the significance of the mitigation effect and the achievement gained through structured OHSs.

Salminen (2011), conducted a literature review to determine the occurrence of occupational injuries among immigrant workers. The results of the review reported that immigrant workers were prone to occupational injuries twice more often than the native-born workers. Effective implementation of OH is closely associated to reduction in work related disabilities thereby increasing the quality of years spent at work.

In Finland, it is reported that the consumption of OHSs by working population has remarkably increased compared to the general health services (Ikonen, 2012). The main reasons cited for the visits to OH specialists include issues related to musculoskeletal disorders, health conditions proving to be chronic hence impairing work ability, and situations arising from poor work ability. Owing to the vulnerability of the migrant workers and reduced accessibility to OHSs, their health status is likely to be more compromised when considering the mentioned health issues related to work and health.

2.6 International perspective on occupational health services

The importance of primary health care (PHC) was identified during the Declaration of Alma-Ata 1978. The essence of bringing primary healthcare to where people live or work was recognized as an important contributor towards the realization of “health for all” goals. World health Organization (WHO, 1995) emphasized on OH needs of migrant workers owing to their vulnerability. During the 2nd Meeting of WHO Collaborating Centres in Occupational Health, dubbed “Global Strategy on occupational health for All” (WHO, 95), strengthening of OHSs came up as one of the ten priority objectives proposed by the conference. The meeting proposed the strengthening of healthcare systems and enhancement of professional competence among OHS providers. Poor healthcare access by the migrant population is singled out as one of the major contributors to health inequalities. In order to realize the desired goals of Health for All by 2030, enhancement of primary healthcare access is a major priority for healthcare systems.

The existing OHS system in the European Region is considered to be more advanced, comprehensive and well-structured (Burton, 2010). The system is resource-rich and capable to champion the implementation of healthy workplace policies. The OH systems in EU region is also accredited with advising other region’s systems on matters related to wellbeing and healthy workplaces.

However, the access and use of OHSs by the migrant population is impaired by the complexities accompanying migration process. The complexities hinder accessibility and usage of OHSs by the migrant population (Devilla et al., 2011; Nielsen, Hempler, Waldorff, Kreiner, & Krasnik, 2012; Priebe, Sandhu, Dias et al., 2011b; Sandhu et al., 2013; Wafula & Snipes, 2014; Ziemer et al., 2014). Coupled with the dwindling economic prospects, various OH systems continue to face a myriad of challenges related to health

service administration. In diverse environments, the identified obstacles continue to hamper the attainment of health equality in diverse settings (Dias, Gama, Cortes, & de Sousa, 2011; Leong & Mak, 2014) Similar to the challenges experienced by the organizers of the other primary healthcare services, organization and administration of OHSs poses equal challenges to users and providers of the services ((Frank, Liebman, Ryder, Weir, & Arcury, 2013)).

2.7 Organization and provision of occupational health services in Finland

In Finland, OHSs form the integral part of primary healthcare services. The broader objective of OHS is to promote work safety, mental well-being and general health of the employees (Lillsunde, Mukala, Partinen, & Lamberg, 2014). The employer is charged with the responsibility of organizing OHSs in collaboration with the other general healthcare practitioners and specialists. However, for entrepreneurs, joining and accessing OHSs is voluntary. The healthcare needs of workers are the responsibility of the employer. The employers are charged with the responsibility to organize and fund OHSs for their employees.

Today, more than 80% of those who are actively engaged in formal employment are covered by occupational healthcare and 80% are accessing medical care as a package resulting from occupational healthcare benefits. Most of these services are procured from the private clinics with only about 20% coming from the municipal healthcare centres. However, the cost of providing OH care incurred by the employer is partially reimbursed by the National Sickness Insurance (Laamanen et al., 2010). Healthcare services provided by the private practitioners are usually located in well-equipped facilities with both general and specialized practitioners. The services provided by the private sector are subsidized and up to 30% of consultation fee, investigations and treatments are reimbursed by National Sickness Insurance (Health Insurance Act, 1224/2004).

According to the revised act of Occupational Health Care Act (1383/2001), collaboration between employer, employee and OHS unit is deemed to be important. The Act emphasizes the importance of the process since it enhances health and workability through prevention of occupational injuries and treating general illnesses. In Finland, OHS is designed to protect workers by contributing to a healthy and safe working

environment. At the same time, OHS promote well-functioning environment for workers. In addition, Finnish OH system offers more comprehensive services compared to the other EU member countries. Therefore, Finnish OH system may prove to be complex posing challenges both to the healthcare providers and users of the services (Kinnunen-Amoroso, 2013).

2.8 Occupational health services access and usage by migrant workers

As already discussed in the preceding sub-chapters, the organization and provision of OHSs to the migrant population is never smooth without challenges. While assessing the past studies conducted on the topic, the results indicate variations in OH status when comparison was made between migrant workers and the native-born population (Ahonen & Benavides, 2006; Flynn, Check, Eggerth, & Tonda, 2013; Panikkar et al., 2013).

According to the results of a study conducted by Smith and Mustard (2010), the negative OH outcome reported among migrant workers was precipitated by diverse factors. The study was conducted to assess the distribution of OH and safety risks among migrant workers in Canada. The study results highlighted the unequal distribution of OH and safety risks among migrant workers compared to the native-born Canadians. The results pointed out the increased susceptibility of migrant workers hence, increased occupational health risks and reduced work safety. The study findings attributed the increased risks among migrant workers to lack of knowledge regarding work place rights and protections in work environment. Therefore, the knowledge deficit instigated the reported poor OH status and the compromise of safety reported among the studied population. (P. M. Smith & Mustard, 2010)

Similarly, a critical review conducted to evaluate occupational health disparities among Asian American workers in USA, identified various factors that aggravate OH disparities (Leong & Mak, 2014). The study identified occupational segregation as one of the major contributors to poor health status among the migrant population. The occupational segregation experienced by Asian American workers resulted to physical and environmental hazards, work stress and poor working conditions. Consequently, the study recommended for increased inclusiveness and advanced parity in occupational health services. According to Leong and Mak (2014), “parity, or equity, seeks to eliminate disparities by examining the process of health services provision and health promotion, as well as the desired outcome” (p. 48). Supported by McCauley (2005), OHS providers are encouraged to develop cultural competence in order to enhance care provision in a multicultural environment. Precisely, bilingual skills and cultural competency of OHS providers would contribute towards provision of efficient and culturally sensitive healthcare services.

In Finland, few studies have been done to assess the concept of OHSs and access among workers with foreign background. However, studies done to assess migrants’ perceptions and experiences of primary healthcare services have elicited mixed results. Degni and colleagues (2014) studied the perceptions and experiences of Somali-born women in regard to access and use of maternity health services. The results of the study reported general satisfaction of the services by the service users. However, the study participants expressed various challenges encountered in the process of accessing the services. The identified obstacles emanated from communication difficulties attributed to lack of common language, cultural differences and even perceived unfriendly social interactions with the care providers (Degni, Suominen, El Ansari, Vehviläinen-Julkunen, & Essen, 2014).

2.9 Factors facilitating healthcare access

Factors that determine the access and utilization of healthcare services by the migrant working population are vast and diverse. The factors are significant and worth according consideration when assessing the access and usage of OHSs by the migrant population. Acknowledging the implications accompanying reduced OHSs access, promoting the factors that advance OHSs access would go a long way towards realization of OHSs objectives. Diminished access to OHSs is reported to pose negative implications upon health status of migrant workers. The results of obscured access to OHSs is considered to be multifaceted with the resultant effects extending beyond individual worker's health.

Past studies done to assess OHSs access among the migrant population identified various factors cited to enhance the access of the services. Some of these factors included the geographical location of service provision sites, the topographical terrain, transport and communication channels (Arnold, Theede, & Gagnon, 2014). The geographical accessibility encompasses the distance travelled and the costs incurred to access the services (Safran, Cohen, Caplan, Ohuabunwa, & Pharagood-Wade, 2005). In a multicultural environment, the users of the services would also consider the cultural diversity of healthcare providers (Frank et al., 2013). Additionally, the adequacy of the OHSs personnel in the service facilities will determine the pattern of access and use of OHSs (Safran et al., 2005).

Arnold and colleagues (2014), conducted a study in Kenya to explore the access of healthcare services by urban migrant population in Nairobi. The results of the study identified long waiting time, proximity of the service provision sites, costs of the services and acceptability of the services by the consumers as some of the factors that determined the access and use of the services. The proximity of the services to the potential users

determine the access and usage of the services. Equally, the study identified the easy communication and transport means in the urban setting as a promoting in access and use of healthcare services by the studied population.

Similarly, another study was conducted by Carballo and Nerukar (2001) in France and Germany among workers with foreign origin. The results of the study identified increased cases of industrial injuries and permanent accidents among migrant workers. The number of the injuries was noted to be higher among foreign workers compared to the native-born workers (Carballo & Nerukar, 2001). The higher number of industrial accidents and permanent injuries was associated to the untreated health conditions among the foreign- born workers. The untreated health conditions impaired concentration at work place thereby, reducing work efficiency among migrant workers. In addition, the researchers postulate that the essence of cultural conflict between migrant population as service users and the native-born population as care providers likely impeded the accessibility of OHSs to migrant workers.

2.10 Structural factors that promote or inhibit healthcare access

The aspect of inhibited fear among migrant population resulting from perceived discrimination by the host community is also considered a hindrance to accessibility (Coelho & Nguyen, 2012). The perceived hostility of the healthcare to the minority population is likely to create a wedge between health providers and service seekers. In this regard, the users of the services would seemingly harbor less interest and reduced help seeking practices towards the available services. This would be observable regardless of the proximity of the services to the potential users (D. Smith & Ruston, 2013).

The essence of communication in healthcare provision plays a core role in facilitating the entire process. Communication alone would not be considered relevant if not implemented appropriately. In a multicultural environment, effective communication is necessary in facilitating the entire service provision process (Palmgren, Jalonen, & Kaleva, 2008). Lack of common language between healthcare provider and users of the services renders communication ineffective thereby impairing treatment process. Lack of language skills by migrant population in the host country is cited as a major impediment to healthcare access.

Dembe (2001) posits, lack of bilingual and culturally trained healthcare providers is a major challenge in service delivery in multicultural environment (Dembe, 2001). Consequently, he recommends for re/training of healthcare providers on multicultural issues to enable them operate effectively in culturally diverse environments. In addition, he recommends for the availability of health information in a language that is vastly understood by the migrant population.

Similarly, another study was conducted in Australia to assess the role of communication among patients with foreign origin identified the aspect of culture and presence of common language as contributors to effective communication (Jowsey, Gillespie, & Aspin, 2011). The study also identified the role of culture in communication and presence of linguistic skills as core determinants of communication process. Lack of language skills exhibited challenges encountered between care providers and care seekers. The findings are supported by Degni and colleagues (2014) study. The results of their study identified lack of language skills, communication incompetence and cultural differences as some of the hindrances to healthcare access. It is also emphasized that, recipients of healthcare

services consider presence of a common language and interpersonal communication skills as important facilitators of service delivery (Migge & Gilmartin, 2011).

Another important aspect in health care delivery is the existing knowledge about the structure of healthcare system. The availability and access of information related to available services and the structure of health system act as a bridge linking healthcare users to the actual services. In the absence of such information, the users of the services are prone to be detached from the healthcare system hence, experiences of difficulty in navigation through the healthcare system.

A study was conducted to assess barriers to healthcare access by Chinese workers in Netherland. The results identified lack of information about Dutch healthcare system as one of the barrier to accessibility (Liu, Ingleby & Meeuwesen, 2011). The study reported that those who had lived longer in Netherlands had better knowledge about the healthcare system thereby, improving accessibility. Additionally, better understanding of the Netherlands' healthcare system among the studied population was perpetuated by the ability to command the Dutch language.

Lack of information concerning the available healthcare services is also identified as a factor likely to slow the access of OHSs by the migrant workers. (Leong & Mak, 2014; Migge & Gilmartin, 2011). When the information touching on the scope of the available services is concealed to the users of the services, the intention to use the services is likely to be compromised leading to reduced health seeking practices.

3 RESEARCH PURPOSE, RESEARCH QUESTIONS, AIMS AND RATIONALE

The main purpose of this research is to explore migrant workers' understanding of OHSs and bring out their expectations and experiences of the services. The study makes a qualitative investigation on the utilization of OHSs by migrant workers in the Finnish context. The aim of the study is to assess the lived experiences of OHSs from the migrant workers' perspective.

The study seeks to answer the following research questions:

- How do migrant workers understand the concept of occupational health services?
- What are the migrant workers' expectations of occupational health services?
- What experiences do migrant workers have in relation to access and usage of occupational health services in Finland?

4 RESEARCH METHODOLOGY

4.1 Study Design

Qualitative study design was used to implement the study. According to Mowat and Swinton (2006), qualitative research is useful in mapping and exploring the meaning of an area of human experience. Qualitative research design deemed appropriate for the study. The study design facilitates the process of bringing out the voices of migrant workers regarding their experiences of access and use of occupational health services. Qualitative research method is also accredited with the potential to bring out an inherent rigour arising from data collection and analysis (Lincoln & Guba 1985). The rigour supports the essence entailed in understanding a phenomenon from the studied subjects' perspective. (LoBiondo-Wood & Haber 2010; Green & Thorogood 2009).

4.2 Sampling

Information concerning the study was conveyed to prospective participants through phone calls, physical meetings and email messages. Purposive sampling method was used to access the rich source of data. The researcher being an immigrant employee in Finland, utilized the avenue to identify migrant workers with the potential to participate in the study. At some point, snowball sampling method was used to identify other study participants. Some of the participants referred the researcher to other potential interviewees. According Green and Thorogood (2009), accessing information-rich cases sometimes require application of different sampling strategies. Through the identified participants, contacts of other potential participants were acquired who later accepted to take part in the study. The criteria used for this purposive sampling included:

- Being a non-Finn
- Persons of 18 years and above
- Workers with official residence status in Finland
- Formally employed in Finland

4.3 Data collection

Data was collected through face-to-face interviews by the researcher. Interview sessions were conducted and guided by semi-structured interview questions (appendix 2). Treacy and Hyde (1999) emphasize, semi-structured interview questions allow the interview sessions to go in any direction that supersedes the boundaries of the designed format.

The interview questions were constructed under; understandings of occupational health services, expectations of workers of these services, and experiences arising from occupational health services. Semi-structured interview questions included demographic data, past work experience in one's home country, settling process in Finland, work experience in Finland, expectations of OHSs, past experiences related to access and utilization of the services. A total of fifteen immigrant employees were contacted and agreed to participate in the study. However, during interview sessions, the researcher noticed that saturation point had been attained by the twelfth participant. Therefore, a decision to conclude the interview process by the twelfth interviewee was reached. All the interviews were tape-recorded with the permission of the participants. The interviews were conducted in places agreed by the participants such as homes, restaurants, and even recreational parks.

4.4 Data Analysis

The audio-taped interviews were transcribed verbatim by the researcher and this formed part of the analysis process (Braun & Clarke, 2006). The transcribed interviews were then read and re-read while making notes. This process contributed to the familiarization stage and facilitated the researcher to get immersed in the data (Eto & Kyngäs, 2008; Graneheim & Lundman, 2004). According to Vaismoradi and colleagues (2013), the process of reading the transcripts several times aids in achieving the sense of the whole (Vaismoradi, Turunen, & Bondas, 2013). Initial codes were then generated from the meaning units in form of words, sentences or paragraphs. The meaning units were key ideas within the text addressing particular issues related to specific research questions. This process of generating initial codes was repeated throughout the transcribed notes. The identified codes were then grouped together to form themes addressing similar issues of the studied phenomenon. The next stage involved reviewing of the identified themes to identify their commonalities and refine their meanings in relation to the research questions. The identified themes and sub-themes are presented in the results section.

4.5 Ethical considerations and informed consent

Human dignity should be upheld when conducting studies that touch on the personal lives of the study subjects. Ethics and the respect to human rights are the foundation to understanding informed consent (Ferney 2008). Helsinki Declaration emphasizes on the importance of adhering to human rights principles. It depicts the importance of treating human beings as an end to themselves rather than using them to achieve other goals.

In this study, ethical issues were observed throughout the study. Study objectives, purpose and aims were clearly explained to the study participants through an introduction letter (appendix 1). The voluntary nature of participation was also explained to the participants. They were made to be aware about the freedom to participate in the study, stop at any stage and even to drop out of the study at own volition without any repercussions. Each of the study participant was made to be aware about tape recording of the interviews. Informed consent was obtained from every participant who took part in the study. The interviews were anonymously recorded. No personal identification particulars that could be associated with a participant were included in the data.

5 RESULTS

5.1 Participants' background information

The study was conducted in Tampere, south west of Finland. A total number of participants who took part in the study were twelve, six males and six females with ages ranging between 25 and 45 years. The duration of stay in Finland was ranging from 4 years to 12 years. Over 67% of the participants were married and had their families either in Finland or back in their home countries. All of the participants were documented migrants who had moved to Finland either to study or to work. They were all educated with at least bachelor's degree. All of the participants were formally employment with work contracts of at least one year and above. The areas of employment were; facility management and housekeeping, metalwork and fabrication, healthcare, business management, education and research. The countries of origin were Ethiopia, Uganda, Zambia, Tanzania and Kenya.

5.2 Migrant worker's perceptions of OHSs

Over 90% of the participants had already engaged in formal employment in their home countries before migrating to Finland. Therefore, some of them at some point had utilized occupational health services. A few of the participants had even engaged themselves in more than one employment and were willing to share the experiences gained from utilizing various workers' health services.

All of the participants had knowledge about OHSs. They perceived OHS in Finland to be superior, advanced and well-structured relatively to the services in their home countries. Considering that all participants came from developing countries, they expressed their perceptions of Finnish OHSs in regard to their past exposure to similar services. They

perceived occupational health services to offer preventive, curative, health promotion and even psychosocial support to workers.

5.3 Expectations of OHSs

The participants expressed their expectations of OHSs ranging from services just containing basic medical care to specialized care. They acknowledged the superiority of the Finnish healthcare system in comparison to their countries of origin. Nevertheless, this did not deter some of them from expressing their high expectations of the system. The expectations raised dwelt on the professionalism and culturally sensitive health services. Most of the participants expressed their desire to be handled as equal as other service users. They also expressed their expectation and desire to be understood and treated with respect. They appreciated the primary healthcare services offered in form of OHSs and felt that their health needs would be taken care of adequately. Some of the participants made the following comments:

“I expect to get basic services that will help me to keep fit at work. I know this is somebody’s business, I cannot expect too much from my employer. If the company can just offer me basic medical services, I will be satisfied” (female participant)

“I expect to be treated with respect, given time to explain myself and be understood. I expect to get quality services just like other clients” (Female participant)

However, few participants who were privileged to access superior OHSs in their home countries did not shy away from expressing their expectations of the services. They felt that OHSs should offer more than just basic healthcare services. They expected the OHSs

to offer inclusive medical services. Their expectations were shaped by their previous experiences of OHSs.

“In my last work place before I moved to Finland, we had very good healthcare cover. I was covered together with my family. Every family member was allocated some good amount of money for both outpatient and inpatient treatment. This was an American company. It had a comprehensive medical cover for the employees. I expected to find even better services in Finland” (Male participant)

5.4 Determinants of OHSs experiences

5.4.1 Friendliness and professionalism in service delivery

All participants who had used occupational health services felt that the service providers were friendly in regard to how their cases were handled. They drew their motivation to use the services from the friendliness of healthcare providers. They also expressed their satisfaction with the services offered and highly esteemed the healthcare providers as being professionals and competent. They felt that despite communication challenges encountered, the healthcare providers interacted with them in a professional manner. The attitude of the staff was encouraging and provided the motivation to seek for the services regardless of the challenges faced.

“I had all this aching in my body. I did not know what it was. They went step by step eliminating what they thought was my problem until they found out my problem. The fact that they did not dismiss me was really encouraging to me. Although I did not explain myself clearly, somebody was willing to listen to me. I

was impressed how they took their time to help me. The rest of the operation was well done except of the complications which I did not have control over” (Female participant.)

“I prefer to visit our company clinic than to visit the health centre. Staffs are friendly and some can speak to me in English. I remember during my first visit, they did not only treat my medical problem but also provided me with information on diet and how to keep myself healthy at work” (Male participant.)

5.4.2 Continuity and coordination in the care continuum

The participants also expressed their special encounters with healthcare services beyond basic care. For some of the participants, the referral process was effectively undertaken. For those who had required referral services for further treatment, experiences of satisfaction were expressed. The referral process was meticulously executed and the concern medical need taken care of to the satisfaction of the participant. They expressed their observation about the OH system as being well-structured and coordinated. They also observed that the health personnel do not hesitate to utilize the next level of care whenever there is need. The actions taken in these processes met the expectations of the participants.

“Sometimes back, I had developed a knee problem and needed to see the doctor. The doctor advised me that I required the services of the physiotherapist. I had to visit the physiotherapist in a different location. Upon my arrival in this place, I was surprised to realize that my particulars were already here. The physiotherapist already knew what to do and I did not have to explain myself again. I was really happy about this process” (Male participant)

“Their services are really nice. For example, when I felt ill and visited my company clinic for the first time, I did not completely understand my problem. When I visited the doctor, he did not only prescribe to me medications and let me go back home. He sent me to a specialist where I was further tested. They were friendly to me and showed a lot of concern of my case. This made me to feel that I was in the right place and in safe hands. They kept following me up and made sure I got the best services. Whenever I called, they were courteous and responded adequately to my concerns”
(Female participant)

5.4.3 Physical accessibility of OHSs provision units

Participants who had accessed the services expressed that the facilities offering OHS were adequate and easily accessible to the employees. They also felt that most clinics are situated in the city center with easy accessibility. For some of the participants, clinics are also easily accessible around the city center making it unnecessary to travel all the way to the city center. In some organizations, the branches were spread across major cities in Finland. This provided easy access for those who had to travel around the country on official duties.

“My work involves moving around in different cities to meet other work colleagues. I am happy that I can access the healthcare services in any major city in Finland. My health provider has clinics in most cities in Finland. I have only to present my work identification card and I will get treated” (Female participant)

“I work in different places outside the city center. I am happy that I don’t have to travel back to the city center to see the doctor. There are other branches of this company outside the city which I can visit whenever I feel sick” (Male participant)

5.4. Factors contributing to unmet expectations

5.4.1 Inaccessibility to health related information

Majority of the participants expressed the challenges they had experienced while accessing health information. They felt that information given to them during orientation did not address OHSs. According to most of the participants, quite a number of the organizations they associated with did not provide information related to the availability of OHS. The process of receiving such inform was either delayed or never happened at all. They did not know what services were offered, where they were offered and even the operating hours. They attributed lack of the information to failure to entrench OHSs in orientation programs. Therefore, the information was always overlooked and did not form part of the orientation sessions. However, where the information was integrated in orientation program, it was in Finnish and sometimes only in pamphlet form. This made it even more difficult for the employee to understand the content of the pamphlets. In some cases, the information was only given when an employee was already sick and needed to visit a healthcare provider.

Resultantly, participants expressed how they had to use different ways to acquire such information. In some cases, they had to seek for this information from workmates, relatives, and even friends. In very extreme cases, some went as far as searching for the information from the Internet especially when it was not adequately provided.

“It was one Sunday morning, I got injured while working in one of my work stations. I was cleaning one place and accidentally got pricked by a needle. I felt totally

confused. At first, I did not know what to do. After a short while, I decided to call a friend and ask for advice. My friend advised me to rush to the emergency department in the central hospital. Here, I ended up not being treated. The doctor only talked to me and reassured me that nothing serious could have happened. Still worried, I decided to call my boss and ask for what to do next. My boss informed me that I had to visit the company clinic the next day, which was Monday. This was really stressful moment for me. Later, I received good services and I am still being followed-up” (Male participant).

“In my current employment, I have no information about health services. The boss did not inform me about the availability of any healthcare services. But sometime last year, I had flu and needed to visit a doctor. One of my work colleague advised me that I could visit the health clinic which has been contracted by our employer. I was very surprised to learn about existence of a company doctor. I think will not bother to ask the boss about this issue since I am still on probation and fear losing my job” (Female Participant)

To some of the participants, they perceived lack of information regarding availability of OHSs as an intentional tactic by employer to deny employees the services in order to reduce operation costs. They felt that employers are not willing to deliver OHS information to new employees as a deliberate attempt to limit the visits to OHSs hence, save on the costs of providing these services.

“I understand that it is costly to provide health services to workers in Finland. I feel that the boss may decide not to inform new employees immediately about the services so that the visits to the doctor are reduced. You know, this is business and everybody would like to reduce the cost of doing business” (Male participant)

5.4.2 Lack of language skills as a communication barrier

Majority of the participants rated their Finnish skills as average. At the same time, majority of the participants did not require Finnish language skills in their workplaces. Lack of Finnish language skills posed a major hindrance to accessing OHSs for most of the participants. Despite the fact that participants' length of stay in Finland ranged between four and twelve years, majority of the participants still lacked adequate Finnish language skills. Therefore, communication became challenging in cases whereby the service provider did not have adequate English skills. The difficulties experienced ranged from booking of the appointments to the actually consultation sessions. Some of the participants had even attempted to book for the appointments through telephone calls but were never successful.

“Two years ago, I was sick and needed to call the clinic to book for doctor’s appointment. By then, I did not speak any Finnish. I had hoped that whoever will answer my call would speak English. To my surprise, the nurse was speaking only Finnish and speaking very fast. I did not understand anything. I tried to explain myself in English but she only continued in Finnish. Before I could think of what to do next, the phone was hanged up. Very frustrated, I decided not to call again and just to forget about my sickness” (Female participant)

“Last year when I moved here, I happened to visit the doctor here in the city. The doctor was speaking to me both Finnish and English. It was difficult to understand what the doctor was saying in Finnish especially when he missed the words in English. Although I was treated, I felt that I needed somebody to translate to me what

the doctor was saying. Well, I understand some Finnish but not very well. I will definitely miss to understand the instructions if only given in Finnish” (Female participant)

5.4.3 Use of translators as communication facilitators

The role of translators in communication also came out as an important issue. Participants who had used the services of translators expressed their satisfaction with the services. According to them, translation services were very important especially for those who had limited Finnish language skills. At the same time, clients who had found themselves in difficult communication situations made suggestions for the use of the translation services. One participant who had relatively longer experience of translation services expressed her willingness to advice other foreigners to use the services. She felt that translation makes communication easier and eliminates misunderstandings.

“I have lived in Finland for over six years, I had never been told that I could use translators when seeing the doctor. But when I moved to this city and I had to see the doctor, I was informed that I could use a translator during my next visit to the doctor. I have now used the services two times and feel they are really good. I use translation services even in the daycare when I am meeting with the teacher. When it comes to health issues, I cannot compromise. I have to be sure I am understood and I too understand doctor’s instructions. If possible, I should be addressed in my mother tongue. I will continue to use the services of a translator” (Female participant)

For the participants who had used the translation services, highly appreciated the role of translators. However, they felt that they are not sufficient enough to meet the needs of foreigners in Finland. Those who had secured the services through mobile phone did not hide their disappointment of the process. They over emphasized the need to make the services more accessible. At the same time, the preference of using face-to-face translation overrode phone translation. Despite the growing demand of translation services, the participants felt that the services are still not readily available.

“Last time I needed to see the doctor, I was informed that I will have a translator from a neighboring city. The translation was done through the phone. I can say that it worked fine. However, I think it would be better to sit with the translator in the same room. I think people trained to offer translation services are still not many in Finland” (Female participant)

5.4.4 Ability to navigate through the health system

The participants also expressed the challenges encountered while navigating through Finnish healthcare system. To understand how the structure of the Finnish healthcare system functions, some participants felt that they needed some guidance. This was especially in cases where the participants did not understand Finnish. In some cases, the participants were of the opinion that the information about the available health services could have been given to them but in Finnish language. This made it difficult to understand the operational structure of the healthcare system. The participants also expressed the difficulties experienced in the appointment booking process. Considering that all of the participants hailed from developing countries, reservation of consultation time through phone call might have been new and challenging system.

“I have never understood how the process of using the company clinic operates. I work for two companies. In one company, I can see the doctor even during my free days. In the other company where I perform similar duties, I cannot see the doctor during my free days. I don’t understand exactly where the difference is. This health system looks somehow complicated for a foreigner to understand. I hope they will not one day surprise me with a huge medical bill to pay for the services I have ever accessed” (Male participant)

“When I had just lived in Finland for three years, I visited our company doctor here in the city. I received very good services and I left the clinic satisfied. But when I presented my prescription to the pharmacy to collect my medications, I was shocked to be asked to pay for the medicine. Nobody had explained to me that in Finland everybody pays for their medications. I had to seek for advice from the company’s human resource manager about this issue. I came to understand more about the Finnish health system after this incidence” (Male participant)

“I know that we have a psychologist whom we can consult in our company clinic. The only problem we have is that employee cannot just directly book for an appointment to see the psychologist. There is a process to be followed which I think is quite a long bureaucracy” (Female participant)

5.4.5 Preference for linguistic and culturally competent providers

Due to the fact that all participants were from English speaking nations, their desire to receive health information in English was strongly expressed. Even though each

participant had undertaken Finnish language course at some point, majority felt that they were still not competent in Finnish language. They felt inadequate to use it during consultation visits. Those who had accessed OHSs but were not able to communicate in Finnish expressed the frustrations encountered. This was further exacerbated by the fact that the healthcare provider lacked English language skills. Therefore, some participants openly expressed the harbored fear of being misunderstood or failing to understand healthcare provider. For this reason, they did not hesitate to express their desire to receive services from bilingual speakers.

“Last year, I was visiting the physiotherapist whom I was told could speak English. During the sessions, we had difficulties understanding each other. At some point, she had to Google for information from Internet. I was there lying on the couch waiting. This made me somehow to lose confidence in whatever she was doing. I was left wondering. Does she really know how to deal with my problem? At some point she was giving me instructions in Finnish. I did not really understand her but I kept nodding and saying ok...ok...ok. I left the place feeling that it is better to visit a doctor who can speak to me in the language I understand” (Male participant)

Some of the participants also expressed their perceived fear arising from cultural differences. Owing to the fact that they came from a different ethnic background, feeling of doubt of not being adequately understood was strongly expressed. This was especially associated to situations whereby one had to explain about signs and symptoms of uncommon illnesses. Therefore, they expressed their desire for health care personnel with multicultural background in the Finnish healthcare system.

“I always wonder how well the doctor understands my problem. Imagine that we come from a different environment with different diseases. When you are explaining

about some of these diseases that are not common here in Finland, how will the doctor understand it? I think that we need doctors with foreign background who can understand foreigners better” (Male participant)

“Currently, there are many trained foreign healthcare workers in Finland. But the issue is always the lack of money to pay them. I wish they could employ more doctors to reduce the workload normally experienced during summer period. By the way, an African doctor can understand African patient better. They should consider employing more foreign doctors” (Female participant)

5.5. Participant’s health related concerns arising from work environment

5.5.1 Lack of social support, impediment to workers’ wellbeing

To some of the participants, lack of social support at work place had a negative impact in their wellbeing. For those participants who were no longer in school, making contacts outside workplace was sometimes challenging. Therefore, they proposed that the management should initiate social groups at work place to bring the workers together outside work environment. Some of the participants felt that through such networks, they would be able to access some important missing health information.

“Sometimes back, I was using the gym services and paying by myself. This happened for a while until one day we met with one of my work colleague. She was not amused to see me pay for the services. She later asked me whether I did not want to use the coupons provided. I was like, which coupon and from where? She informed me that

we are entitled to these coupons and I could access them from the human resource manager” (Male participant)

“In my former employment back in my home country, we had a welfare committee taking care of workers socioeconomic needs. The committee received information about the welfare of workers then reported to the management. In Finland, we lack such social support at work place. An employee cannot be efficient at work if s/he has some family problem. I think that foreign workers need social support to help them cope in this new environment. Imagine working in some place where you cannot communicate with your colleagues because of language barrier. And the boss also does not even care to find out whether you have a family and how the family is doing. When somebody has social problem in their family they cannot perform adequately at work.” (Female participant)

5.5.2 Health education and periodic health check-ups

Majority of the participants expressed their desire to access health education in their work places. They felt that being in a new environment would predispose them to some unknown health and environmental risks. Therefore, they felt that receiving health information from an expert would help them to lead a healthy working life. At the same time, they expressed their desire for information related to handling emergencies at work place like fire and performing first aid services. Additionally, they felt that periodical medical check-ups if done would aid in detecting unhealthy conditions arising from working environment.

“We sometimes work in isolated sites very early in the morning or late in the evenings. I think we should be shown at least how to help in case somebody sustains an injury that needs immediate attention. For examples, in some of the work sites, one is there alone late in the evening cleaning the place. It really feels risky and scary to clean under those huge machines in the absence of regular employees” (Male participants)

“I have this one factory full of heavy machines that I normally clean every weekend. I was always scared in this place because some machines are still running by the time I am cleaning. My worry was always that I did not have information on what to do in case there would be something like fire outbreak. I was forced to approach my supervisor to ask for information on what to do in case of an emergency. She promised to consult that company and even to organize for some trainings” (Male participant)

5.5.3 Pre-employment medical examination as a compulsory requirement

The participants who did have pre-employment medical examination did not fail to express their dissatisfaction with the system. Those who were engaged in multiple employments were able to compare and contrast pre-employment requirements and therefore, could easily realize variations between the organizations. Despite the fact that they were doing the same type of work in more than one place, they observed that the pre-employment medical examination was not uniformly performed across different organizations. To some participants, pre-work medical examination was observed not to be mandatory in some institutions. They expressed their desire for the pre-employment medical examination to be mandatory.

“I had working for only one company until late last year when I got another work place. In this new place unlike the first one, medical examination was not a requirement. I was just shown what to do on the first day and the next day I started working. I have been working in this place now for over six months without medical examination. I was given some form to take to the doctor but it was written in Finnish. Nobody has asked me about it and I have never bothered to ask somebody to translate it to me” (Male participant)

“In my first employment, we were using heavy washing machines. Interestingly, no medical examination was required prior to the employment. In my current employment, the arrangement was totally different. I had to visit the doctor where some tests were done before I could be employed. Actually, the department’s manager informed me beforehand that she would have to call the doctor for the results before letting me know when I would start working” (Female participant)

The raised health related concerns arising from workplace environment depicts the multidimensional activities encompassing pursuit of health and wellbeing among the working population. Despite the concerted efforts directed towards treatment and rehabilitation of ill health, equal and even more efforts would be needed to improve the work environment in order to enhance workers’ safety and wellbeing.

6 DISCUSSION

The aim of the study was to assess the perceptions of migrant workers and to bring out their expectations and experiences of OHSs in Finland. The results of the study point out that most of the participants were aware of OHSs and had at some point used the services. They expressed different expectations of the services that dwelt around professionalism, equality of services and culturally sensitive care. The expressed expectations might have resulted from the previous encounters they had with healthcare services rendered to workers. The past exposures to healthcare services were traceable back to their own countries of origin. Since some participants had utilized work related healthcare services, the past experiences might have determined their expectations of the Finnish OHSs.

Though the aim of the study was not to assess migrant workers' satisfaction of the services, the participants expressed general satisfaction of Finnish OHSs. However, the participants did not fail to point out the various hurdles encountered in the process of accessing OHSs. Similar to previous studies (Leong & Mak, 2014; Safran et al., 2005), some of the identified hurdles were arising from lack of common language , difficulties in navigating through the healthcare system, cultural aspects and safety issues in workplaces.

Consistent with this study, previous studies have highlighted the importance of acquiring native language skills (Bischoff, Kurth & Henley 2012), which acts as a bridge to link up healthcare providers and the migrant health seekers (Gushulak, Pottie, Hatcher Roberts, Torres, & DesMeules, 2011). Most of the participants in this study expressed the harbored desire to continue studying Finnish language to improve their communication skills. They acknowledge the importance of a common language as a means of overcoming communication barrier. However, the absence of a common language was

not reported to have contributed to any major incidence in OHSs provision. Nevertheless, it is worth noting that, lack of language skills impede smooth communication process hence, precipitate communication breakdown thereby rendering the process ineffective (Dauvrin & Lorant, 2014). The effects of communication breakdown have been associated to misdiagnosis and non-compliance to treatment regimen in healthcare provision (Wilson, Chen, Grumbach, Wang, & Fernandez, 2005).

Similarly, the results of Panikkar and colleagues (2013) study of self-identified immigrant workers living or working in Somerville, found out that the language skills of the participants improved with the years lived in the host country. Those who had lived longer in Somerville demonstrated better English language skills. This facilitated the better communication process and improved their accessibility to healthcare services in Somerville.

In addition, Leong and Mak (2014), posit, inclusive services would consists of multilingual and multicultural healthcare providers. Occupational health services should be made accessible to all workers in languages widely spoken. However, it is noteworthy to mention that acquisition of linguistic skills alone would not necessarily combat communication barriers in healthcare access. It is further argued that, more efforts need to be focused towards improving the entire healthcare system through institutional (re)organization. The professional development of individual healthcare providers also enhances the entire communication process (Komaric, Bedford, & van Driel, 2012).

The difficulties experienced in accessing information regarding the available services are also identified as some of the hurdles facing healthcare users with foreign background in the host country. The complexity of the healthcare systems slows the navigation process

thereby, hindering accessibility and utilization of healthcare services (Wilson et al., 2005). This is supported by the findings of Loignon, Hudon, Goulet, Boyer, De Laat, Fournier, Grabovschi and Bush (2015) study, which identified unfamiliarity of health systems to users of the services as an obstacle to healthcare access and usage of the services (Loignon et al., 2015). According to Degni and colleagues (2014), the navigation skills of healthcare users with foreign background in the host country improves with the years lived in the host country. The longer the migrants live in the host country, the better they get acquainted with the host country's health care system and the better they maneuver through the system.

Similarly, the results of this study indicate that the migrant workers who had lived longer in Finland had better understanding of the Finnish healthcare system. Therefore, they reported better access to OHSs. They were not timid to access OHSs in the native language and even demonstrated willingness to be communicated to in Finnish language. To those who considered themselves to have lived in Finland for just a short period, preference to access OHSs in English was strongly demonstrated. This would signify that accelerated efforts to integrate the migrant population in the Finnish society through Finnish language skills would contribute remarkably towards improving accessibility to OHSs. Meanwhile, the importance of translation services would form the most appropriate means to extend OHSs to foreign workers with inadequate Finnish language skills. Professionally trained medical translators contribute significantly towards the attainment of healthcare objectives (Ngo-Metzger et al., 2003)

Therefore, the identified challenges resulting from communication and language barrier could easily be overcome through programs designed to equip migrant workers with knowledge and skills of the host country's language (Dembe, 2001). Such programs if facilitated by employers, would provide motivation to workers to develop their Finnish

language skills hence, improve communication in healthcare settings. Equally, collaborative approach extended by various stakeholders is important in improving accessibility. It acts as a means of advancing integration of foreigners in to the host country's culture. The process of integration would enhance the flow of health information on basic services. The resultant effects of active implementation of integration programs minimizes language barrier in service delivery. Additionally, integration programs unveil information concerning healthcare structure thereby, improving health services accessibility (Bollini et al., 2009).

The health related concerns raised by the study participants are consistent with the results of earlier studies (Ahonen et al., 2009). Language and communication difficulties coupled with complexity of the system, are likely to occlude vital health information from the migrant workers. In return, this is likely to jeopardize their actions in life threatening situations exposing them to precarious health conditions (Bischoff, 2012).

Another important aspect noted in healthcare access is the proximity of healthcare services to the users of the services. It has been reported that the nearer the services are to the potential users, the better the accessibility and the higher the utilization rate. (Harrington et al., 2012; Migge & Gilmartin, 2011). The results of this study pointed out that the participants had experienced easy physical accessibility of OHSs. This was due to the close proximity of the service provision units to the users' residential places and workstations. However, the close proximity of the services alone does not necessarily translate to better accessibility. As emphasized by Husman and Päivi (2006), high coverage of OHSs alone does not directly translate to better OH outcomes. Therefore, proposals should be directed towards activities that would increase awareness level of health consumers on the available healthcare services. In addition, emphases should be geared towards empowering OHS providers with skills touching on health education,

cultural competence and health communication (Husman & Paivi, 2006; Palmgren et al., 2008). Occupational health service providers who are equipped with multicultural skills are able to identify individual needs of their clients and act sensitively to meet the health needs.

However, some of the shortcomings experienced in the system were complex and could be extending across the entire OHSs system affecting both foreign and native-born users. For instance, the reported shortage of physicians by the participants may not only affect migrant workers but may cut across other users of Finnish OHSs. The reported results of “maintenance of work ability activities” (MWA barometer, 2001), identified inadequate staffing of OH physicians as an impediment to the success of OH services (P. Husman, 2006). Therefore, the study recommended for adequate OH physicians as a positive attribute towards successful implementation of OHSs programs. This is also supported by Demba (2001), who argues that the implications of inadequate healthcare providers is associated to long waiting time. The consequences of long waiting time in healthcare service provision result to negative health seeking experiences. Whenever clients tend to wait longer for the services, they tend to lose grip on the culture of prompt health seeking practices albeit in chronic and non-life threatening illnesses.

It is also worth mentioning that, better OHSs access was experienced by those employees who were working in relatively larger institutions. In large organizations, there tend to be well-established managerial hierarchy with better communication structure in comparison to smaller organizations. The dissemination of health related information is likely to be more structured. The essence of superiority in organizational structure plays a remarkable contribution in effective information access hence, better understanding of the healthcare system. The study findings by Kimanen and co-workers (2011), elicited the size of the company as a contributory factor to the access of primary health providers.

The study assessed the visits made by workers to OH physicians and nurses in Finland (Kimanen et al., 2011). As supported by Plomp (1996), accessibility and the utilization of OHSs is largely determined by the size and the institution's organizational structure. Considerably, the success of healthcare system and public health programs would be pegged on their design and how sensitive they are to meet the health needs of migrant workers (Schenker & Gunderson, 2013). The essence of diversity of OHSs would involve the creation of assessment and monitoring units within OH systems. This supports individualized healthcare services and promotes cultural sensitivity.

Past studies have also associated socioeconomic status of the healthcare users with access and usability of the services. For instance, the low socioeconomic status of migrant workers in the host country has been reported to inhibit access and utilization of OHSs (Frank et al., 2013). However, the results of this study did not identify any relationship between the socioeconomic status of migrant workers and their accessibility to OHSs. Nevertheless, it is prudent to point out that the potential of the other identified factors, if not checked, could easily impede OHS access among migrant workers in Finland. Despite the advanced Finnish OH system that buffers workers from health service costs, the other identified factors have the potential to inhibit the accessibility of OHSs by migrant workers.

Even though health promotion was not one of the components of the study objectives, the contribution made by such programs to promote healthy work life, captured the attention of the study participants. Their appreciation and reservations about these services was strongly expressed. The users of these services pointed out the shortcomings experienced in the implementation of such health promotion programs. As advocated by Peltomäki and colleagues (2003), workplace health promotion programs needs to be multifaceted, workers driven and should embrace participatory approach. Participants

of the study appreciated the initiatives adopted by various employers to promote employees' health. However, they suggested for refining of the programs to meet the individual worker's health needs. Migrant workers are identified to belong to precarious group of workers. The healthcare needs of migrant workers should be accorded the desirable attention in order to mitigate the effects of ill health in working environment. Therefore, OHSs programs when executed appropriately, has the potential to promote workers' health and enhance workability (Peltomaki et al., 2003).

6.1 Study strengths and limitations

At this point, it is important to bring out the strengths of the study while acknowledging the existence of limitations. The study draws its major strength from the fact that there is still scarce knowledge tackling the experiences of OHSs among workers with foreign origin in Finland. In the best knowledge of the researcher, the literature reviewed did not reveal the existence of any qualitative studies conducted in Finland to explore migrant workers' experiences of OHSs. Therefore, the strength of this study is inscribed in its approach to unravel lived experiences of workers with foreign background in Finland emanating from their interactions with occupational health providers in pursuit of OHSs.

It is also noteworthy to highlight that the results of this study are in concurrence with the findings of past studies conducted elsewhere to explore similar phenomenon. The results of the study resonate with and concretize the similarities and contrasting features already identified by previous studies comparing the access of OHSs between foreign and native-born workers.

The study was planned and executed by a researcher who himself is also a migrant worker. The researcher used his network to identify and contact the potential participants considered to be information-rich. The study used primary data collected through face-to-face interviews in a language conversant to both researcher and the participant. Therefore, misunderstanding resulting from the process of translation was avoided. Yet, the risk of the interviewer and the interviewee sharing a subculture stems from the fact that there exists an area of silent knowledge between them, which may leave some bits of talk unexplicated and compromise the transparency of research. Putting consideration on the ethnicity component, the researcher maintained alertness of this factor while conducting data analysis.

The study also draws its strength from the composition of the study population. Due to the fact that the study sample consisted evenly of six males and six females, the views experienced in the results would not be considered to incline towards one particular sex group. However, it is important to notice that the study sample (N=12) was drawn from a population of one ethnic group only, African. Prior studies have not identified ethnicity as a contributing factor with the potential to determine the use of OHS as it has been reported from nonnative origin and foreign language. Ethnicity is not approached as a contributing factor in this study either. To shed more light on the meaning of ethnicity in using OHS, further studies are highly recommendable.

Overall, the transferability of the study results is grounded on clear documentation of sampling and recruitment methods. The researcher utilized multiple sampling methods to identify potential participants with information-rich characteristics. The credibility and recognizability of conclusions is secured by the intensive process applied in data collection, storage, and analysis.

6.2 Conclusion and recommendations

The study findings replicate previous studies conducted elsewhere to explore the lived experiences of immigrant workers concerning OHSs access and utilization. The challenges encountered by foreign born workers in accessing OHSs are unique and multifaceted. It is worth noting that employment factor alone did not tilt the experiences of migrant workers in regard to healthcare access and utilization. The experienced barriers to OHSs by migrant workers were similar to the experiences reported elsewhere among the general migrant population. Therefore, enhanced efforts to improve the accessibility of healthcare services to the migrant population would equally improve the welfare of migrant workers. Noting that these challenges are not linearly distributed, broadened collaborative approach would go a long way in tackling the identified upheavals. Such efforts, if effectively implemented would bear significant fruits by eliminating the identified barriers, hence actualization of improved occupational healthcare access.

A suggestion is also floated for further research that would advance knowledge on the experiences of OHS providers. Owing to the immense responsibility assigned to healthcare personnel providing services to working clients with foreign-born background, their contribution is equally important. Such studies would further deepen the understanding of the phenomenon from a different perspective. This line of approach highlights the critical issues surrounding healthcare policies and empower healthcare users with necessary information concerning the available healthcare services.

Lastly, continuous inclusiveness of the minority population in the mainstream system would be a significant step towards overcoming the structural barriers. Achieving this goal would involve enhancement of the available integration programs. The role of

common language can never be overemphasized. Equipping the migrant population with Finnish language skills enhances information seeking and improves accessibility of the available services. To be informed is to be empowered!

7 REFERENCES

- Ahonen, E. Q., Porthé, V., Vázquez, M. L., García, A. M., López-Jacob, M. J., Ruiz-Frutos, C., . . . Benavides, F. G. (2009). A qualitative study about immigrant workers' perceptions of their working conditions in Spain. *Journal of Epidemiology & Community Health*, 63(11), 14-14. doi:10.1136/jech.2008.077016
- Ahonen, E. Q., & Benavides, F. G. (2006). Risk of fatal and non-fatal occupational injury in foreign workers in Spain. *Journal of Epidemiology & Community Health*, 60(5), 424-426. doi:10.1136/jech.2005.044099
- Arnold, C., Theede, J., & Gagnon, A. (2014). A qualitative exploration of access to urban migrant healthcare in Nairobi, Kenya. *Social Science & Medicine*, 110(0), 1-9. doi:<http://dx.doi.org/10.1016/j.socscimed.2014.03.019>
- Asanin, J. (2008). "I spent nine years looking for a doctor": Exploring access to health care among immigrants in Mississauga, Ontario, Canada. *Social Science & Medicine*, 66(6), 1271-83.
- Blais, R., & Maïga, A. (1999). Do ethnic groups use health services like the majority of the population? A study from Quebec, Canada. *Social Science & Medicine*, 48(9), 1237-1245. doi:[http://dx.doi.org/10.1016/S0277-9536\(98\)00423-7](http://dx.doi.org/10.1016/S0277-9536(98)00423-7)
- Bollini, P., Pampallona, S., Wanner, P., & Kupelnick, B. (2009). Pregnancy outcome of migrant women and integration policy: A systematic review of the international literature. *Social Science & Medicine*, 68(3), 452-461. doi:<http://dx.doi.org/10.1016/j.socscimed.2008.10.018>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. doi:10.1191/1478088706qp063oa
- Carballo, M., & Nerukar, A. (2001). Migration, refugees, and health risks. *Emerging Infectious Diseases*, 7(3), 556.
- Castaneda, A. E. (2012). Maahanmuuttajien terveys ja hyvinvointi : Tutkimus venäläis-, somalialais- ja kurditaustaisista Suomessa. *Raportti / Terveysten ja Hyvinvoinnin Laitos (THL) = Report / National Institute for Health and Welfare*, 2. uud. p.(61)
- Chung, I. (2010). Changes in the sociocultural reality of Chinese immigrants: Challenges and opportunities in help-seeking behaviour. *International Journal of Social Psychiatry*, 56(4), 436-447. doi:10.1177/0020764009105647

- Clarke, K. (2005). *The problematic of well-being experiences and expectations of migrants and new finns in the finnish welfare state*
- Clarke, K. (2011). Negotiating migrant community needs through social work research. *Qualitative Social Work*, 10(1), 8-27. doi:10.1177/1473325009350673
- Coelho, K. R., & Nguyen, V. T. (2012). Racial disparities in healthcare: Are we prepared for the future? brief report on emergency medical services in a county health department in california. *ISRN Emergency Medicine*, , 1-4. doi:10.5402/2012/340273
- Cortis, J. D. (2000). Perceptions and experiences with nursing care: A study of pakistani (urdu)communities in the united kingdom. *Journal of Transcultural Nursing*, 11(2), 111.
- Daniel, M. (2010). Strategies for targeting health care disparities among hispanics. *Family & Community Health*, 33(4), 329-42. doi:10.1097/FCH.0b013e3181f3b292
- Das-Munshi, J., Leavey, G., Stansfeld, S. A., & Prince, M. J. (2012). Migration, social mobility and common mental disorders: Critical review of the literature and meta-analysis. *Ethnicity & Health*, 17(1), 17-53. doi:10.1080/13557858.2011.632816
- Dauvrin, M., & Lorant, V. (2014). Adaptation of health care for migrants: Whose responsibility? *BMC Health Services Research*, 14, 294-294. doi:10.1186/1472-6963-14-294
- Dean, J. A., & Wilson, K. (2010). "My health has improved because I always have everything I need here...": A qualitative exploration of health improvement and decline among immigrants. *Social Science & Medicine*, 70(8), 1219-1228. doi:<http://dx.doi.org/10.1016/j.socscimed.2010.01.009>
- Degni, F., Suominen, S. B., El Ansari, W., Vehviläinen-Julkunen, K., & Essen, B. (2014). Reproductive and maternity health care services in finland: Perceptions and experiences of somali-born immigrant women. *Ethnicity & Health*, 19(3), 348-366. doi:10.1080/13557858.2013.797567
- Dembe, A. E. (2001). Access to medical care for occupational disorders: Difficulties and disparities. *Journal of Health & Social Policy*, 12(4), 19-33.
- Devilla, W., Greacen, T., Bogic, M., Dauvrin, M., Dias, S., Gaddini, A., . . . Priebe, S. (2011). Health care for immigrants in europe: Is there still consensus among country

- experts about principles of good practice? A delphi study. *BMC Public Health*, 11(1), 699-699. doi:10.1186/1471-2458-11-699
- Dias, F. S., Severo, M., & Barros, H. (2008). Determinants of health utilization by immigrants in Portugal. *BMC Health Services Research*, 8:207. doi:10.1186/1472-6963/8/207
- Ennis, T. (2015). At-risk workers. *Professional Safety*, 60(3), 8-8.
- Erdal, M. B. (2013). Migrant transnationalism and multi-layered integration: Norwegian-pakistani migrants' own reflections. *Journal of Ethnic & Migration Studies*, 39(6), 983-999. doi:10.1080/1369183X.2013.765665
- Eto, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107-115. doi:10.1111/j.1365-2648.2007.04569.x
- Flynn, M. A., Check, P., Eggerth, D. E., & Tonda, J. (2013). Improving occupational safety and health among mexican immigrant workers: A binational collaboration. *Public Health Reports*, 128, 33-38.
- Frank, A. L., Liebman, A. K., Ryder, B., Weir, M., & Arcury, T. A. (2013). Health care access and health care workforce for immigrant workers in the agriculture, forestry, and fisheries sector in the southeastern US. *American Journal of Industrial Medicine*, 56(8), 960-974. doi:10.1002/ajim.22183 [doi]
- Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24(2), 105-112. doi:<http://dx.doi.org/10.1016/j.nedt.2003.10.001>
- Gushulak, B. D., & MacPherson, D. W. (2004). Globalization of infectious diseases: The impact of migration. *Clinical Infectious Diseases*, 38(12), 1742-1748.
- Gushulak, B. D., Pottie, K., Hatcher Roberts, J., Torres, S., & DesMeules, M. (2011). Migration and health in canada: Health in the global village. *CMAJ : Canadian Medical Association Journal = Journal De L'Association Medicale Canadienne*, 183(12), E952-8. doi:10.1503/cmaj.090287
- Harrington, D. W., Wilson, K., Bell, S., Muhajarine, N., & Ruthart, J. (2012). Realizing neighbourhood potential? the role of the availability of health care services on contact with a primary care physician. *Health & Place*, 18(4), 814-823. doi:<http://dx.doi.org/10.1016/j.healthplace.2012.03.011>

Health Care Act 1326/2010 www.stm.fi

- Husman, P. (2006). Occupational health services in finland—do they work well? opinions of the managers. *International Congress Series*, 1294(0), 45-48. doi:<http://dx.doi.org/10.1016/j.ics.2006.02.058>
- Husman, & Paivi. (2006). Challenges of OHS for changing working life. *International Congress Series*, 1294(0), 19-22. doi:<http://dx.doi.org/10.1016/j.ics.2006.02.061>
- Ikonen, A. (2012). Work-related primary care in occupational health physician's practice. *Journal of Occupational Rehabilitation*, 22(1), 88-96.
- International Organization for Migration (2011). Communicating effectively about migration. World Migration Report. http://publications.iom.int/bookstore/free/WMR2011_English.pdf
- Jowsey, T., Gillespie, J., & Aspin, C. (2011). Effective communication is crucial to self-management: The experiences of immigrants to australia living with diabetes. *Chronic Illness*, 7(1), 6-19. doi:10.1177/1742395310387835
- Kankaanpää, E., Suhonen, A., & Valtonen, H. (2008). Promoting prevention with economic arguments - the case of finnish occupational health services. *BMC Public Health*, 8, 130-137.
- Kimanen, A., Rautio, M., Manninen, P., Rasanen, K., Husman, P., & Husman, K. (2011). Primary care visits to occupational health physicians and nurses in finland. *Scandinavian Journal of Public Health*, 39(5), 525-32. doi:10.1177/1403494811399651
- Kinnunen-Amoroso, M. (2013). How occupational health care professionals experience evidence-based guidelines in finland: A qualitative study. *Journal of Evaluation in Clinical Practice*, 19(4), 612-616. doi:10.1111/j.1365-2753.2012.01850.x
- Kirmayer, L. J. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ: Canadian Medical Association Journal*, 183(12), E959-67.
- Komaric, N., Bedford, S., & van Driel, M.,L. (2012). Two sides of the coin: Patient and provider perceptions of health care delivery to patients from culturally and linguistically diverse backgrounds. *BMC Health Services Research*, 12, 322-322. doi:10.1186/1472-6963-12-322

- Laamanen, R., Simonsen-Rehn, N., Suominen, S., & Brommels, M. (2010). Does patients' choice of health centre doctor depend on the organization? A comparative study of four municipalities with different forms of service provision in Finland. *Scandinavian Journal of Public Health, 38*(7), 715-723. doi:10.1177/1403494810379169
- Leong, F. T. L., & Mak, S. (2014). Occupational health disparities among Asian Americans: A critical review with recommendations. *Asian American Journal of Psychology, 5*(1), 44-52. doi:10.1037/a0034907
- Liu, C., Ingleby, D., & Meeuwesen, L. (2011). Barriers to health care for Chinese in the Netherlands. *International Journal of Family Medicine, 1-10*.
- Loignon, C., Hudon, C., Goulet, E., Boyer, L., S, D. L., De Laat, M., . . . Bush, P. (2015). *Perceived barriers to healthcare for persons living in poverty in Quebec, Canada: The EQUIhealThY project*
- Long, J., Hylton, K., & Spracklen, K. (2014). Whiteness, blackness and settlement: Leisure and the integration of new migrants. *Journal of Ethnic & Migration Studies, 40*(11), 1779-1797. doi:10.1080/1369183X.2014.893189
- Malin, M., & Gissler, M. (2009). Maternal care and health outcomes among ethnic minority women in Finland. *BMC Public Health, 9*: 84. doi:10.1186/1471-2458-9-84.
- McFall, D. C., & Yoder, L. H. (2012). Critical access health care: A concept analysis. *Nursing Forum, 47*(1), 9-17. doi:10.1111/j.1744-6198.2011.00245.x
- Migge, B., & Gilmartin, M. (2011). Migrants and healthcare: Investigating patient mobility among migrants in Ireland. *Health & Place, 17*(5), 1144-1149. doi:<http://dx.doi.org/10.1016/j.healthplace.2011.05.002>
- Morrison, S. D. (1995). Developing health education for Hispanic migrant preschool youth. *Journal of Health Education, 26*(4), 207-10.
- Ngo-Metzger, Q., Massagli, M. P., Clarridge, B. R., Manocchia, M., Davis, R. B., Iezzoni, L. I., & Phillips, R. S. (2003). Linguistic and cultural barriers to care. *JGIM: Journal of General Internal Medicine, 18*(1), 44-52. doi:10.1046/j.1525-1497.2003.20205.x
- Nielsen, S. S., Hempler, N. F., Waldorff, F. B., Kreiner, S., & Krasnik, A. (2012). Is there equity in use of healthcare services among immigrants, their descendants, and ethnic Danes? *Scandinavian Journal of Public Health, 40*(3), 260-270. doi:10.1177/1403494812443602

- Norris, T. L., & Aiken, M. (2006). Personal access to health care: A concept analysis. *Public Health Nursing, 23*(1), 59-66. doi:10.1111/j.0737-1209.2006.230109.x
- Palmgren, H., Jalonen, P., & Kaleva, S. (2008). Health education and communication in occupational health services in finland. *Archives of Industrial Hygiene & Toxicology / Arhiv Za Higijenu Rada I Toksikologiju, 59*(3), 171-181. doi:10.2478/10004-1254-59-2008-1888
- Panikkar, B., Woodin, M. A., Brugge, D., Desmarais, A. M., Hyatt, R., Community Partners of the Somerville Community Immigrant Worker Project, & Gute, D. M. (2013). Occupational health outcomes among self-identified immigrant workers living and working in somerville, massachusetts 2006-2009. *Journal of Immigrant and Minority Health / Center for Minority Public Health, 15*(5), 882-889. doi:10.1007/s10903-012-9702-7 [doi]
- Peltomaki, P., Johansson, M., Ahrens, W., Sala, M., Wesseling, C., Brenes, F., . . . Partanen, T. (2003). Social context for workplace health promotion: Feasibility considerations in costa rica, finland, germany, spain and sweden. *Health Promotion International, 18*(2), 115-26.
- Peters, D. H., Garg, A., Bloom, G., Walker, D. G., Brieger, W. R., & Hafizur Rahman, M. (2008). Poverty and access to health care in developing countries. *Annals of the New York Academy of Sciences, 1136*(1), 161-171. doi:10.1196/annals.1425.011
- Priebe, S., Sandhu, S., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E., . . . Bogic, M. (2011a). Good practice in health care for migrants: Views and experiences of care professionals in 16 european countries. *BMC Public Health, 11*(1), 187-198. doi:10.1186/1471-2458-11-187
- Priebe, S., Sandhu, S., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E., . . . Bogic, M. (2011b). Good practice in health care for migrants: Views and experiences of care professionals in 16 european countries. *BMC Public Health, 11*(1), 187-198. doi:10.1186/1471-2458-11-187
- Rantanen, J., Lehtinen, S., & Savolainen, K. (2004). The opportunities and obstacles to collaboration between the developing and developed countries in the field of occupational health. *Toxicology, 198*(1-3), 63-74. doi:<http://dx.doi.org/10.1016/j.tox.2004.01.038>
- Rask, S., Castaneda, A. E., Koponen, P., Sainio, P., Stenholm, S., Suvisaari, J., . . . Koskinen, S. (2015). The association between mental health symptoms and mobility

limitation among russian, somali and kurdish migrants: A population based study. *BMC Public Health*, 15, 275. doi:10.1186/s12889-015-1629-1

Raso, R. (2006). Cultural competence: Integral in diverse populations. *Nursing Management*, 37(7), 56-56.

Safran, E. S., Cohen, L. P., Caplan, L. S., Oluabunwa, U. K., & Pharaogood-Wade, F. (2005). Barriers to occupational and environmental medicine services in the southeastern united states. *Journal of Occupational & Environmental Medicine*, 47(3), 219-225. doi:10.1097/01.jom.0000156398.52427.fc

Salminen, M. (2011). Are immigrants at increased risk of occupational injury? A literature review. *The Ergonomics Open Journal*, 4, 125-130.

Sandhu, S., Bjerre, N. V., Dauvrin, M., Dias, S., Gaddini, A., Greacen, T., . . . Priebe, S. (2013). Experiences with treating immigrants: A qualitative study in mental health services across 16 european countries. *Social Psychiatry and Psychiatric Epidemiology*, 48(1), 105-116. doi:10.1007/s00127-012-0528-3

Schenker, M., & Gunderson, P. (2013). *Occupational health in the dairy industry needs to focus on immigrant workers, the new normal* doi:10.1080/1059924X.2013.797375

Smith, D., & Ruston, A. (2013). 'If you feel that nobody wants you you'll withdraw into your own': Gypsies/travellers, networks and healthcare utilisation. *Sociology of Health & Illness*, 35(8), 1196-1210. doi:10.1111/1467-9566.12029

Smith, P. M., & Mustard, C. A. (2010). The unequal distribution of occupational health and safety risks among immigrants to canada compared to canadian-born labour market participants: 1993–2005. *Safety Science*, 48(10), 1296-1303. doi:<http://dx.doi.org/10.1016/j.ssci.2010.03.020>

Teng, L., Blackmore, E. R., & Stewart, D. E. (2007). Healthcare worker's perceptions of barriers to care by immigrant women with postpartum depression: An exploratory qualitative study. *Archives of Women's Mental Health*, 10(3), 93-101. doi:10.1007/s00737-007-0176-x

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, 15(3), 398-405. doi:10.1111/nhs.12048

- Verbeek, J., van Dijk, F., Räsänen, K., Piirainen, H., Kankaanpää, E., & Hulshof, C. (2001). Consumer satisfaction with occupational health services: Should it be measured? *Occupational and Environmental Medicine*, 58(4), 272-278. doi:10.1136/oem.58.4.272
- Virupaksha, H. G., Kumar, A., & Nirmala, B. P. (2014). Migration and mental health: An interface. *Journal of Natural Science, Biology & Medicine*, 5(2), 233-239.
- Wafula, E., & Snipes, S. (2014). Barriers to health care access faced by black immigrants in the US: Theoretical considerations and recommendations. *Journal of Immigrant & Minority Health*, 16(4), 689-698. doi:10.1007/s10903-013-9898-1
- Wilson, E., Chen, A. H., Grumbach, K., Wang, F., & Fernandez, A. (2005). Effects of limited english proficiency and physician language on health care comprehension. *Journal of General Internal Medicine*, 20(9), 800-806. doi:10.1111/j.1525-1497.2005.0174.x
- Wingate, M. S., & Alexander, G. R. (2006). The healthy migrant theory: Variations in pregnancy outcomes among US-born migrants. *Social Science & Medicine*, 62(2), 491-498. doi:<http://dx.doi.org/10.1016/j.socscimed.2005.06.015>
- Ziemer, C. M., Becker-Dreps, S., Pathman, D. E., Mihás, P., Frasier, P., Colindres, M., . . . Robinson, S. S. (2014). Mexican immigrants' attitudes and interest in health insurance: A qualitative descriptive study. *Journal of Immigrant and Minority Health / Center for Minority Public Health*, 16(4), 724-32. doi:10.1007/s10903-013-9794-8
- World Health Organization (2008). Health of migrants- The wayforward. Report of a global consultation. Madrid, Spain; 2010.
- World Health Organization (1995). Global strategy on occupational health for all. Recommendation of the 2nd meeting of the WHO Collaborating Centres in Occupational Health. Beijing, China 11–14 October 1994. http://apps.who.int/iris/bitstream/10665/36845/1/WHO_OCH_95.1.pdf?ua=1 (Accessed 25.02.2015)
- World Health Organization (2007). Workers' Health: Global Plan of Action. Sixtieth World Health Assembly. http://www.who.int/occupationalhealth/WHO_health_assembly_en_web.pdf?ua=1

Appendix 1

Letter of introduction

Dear participant,

I am a student at the University of Tampere undertaking Master Degree Programme in Health Services, Public Health. Currently, I am carrying out my master thesis on the following topic; "Immigrant workers' perceptions, expectations and experiences of occupational health services". The objective of the study is to explore the expectations, perceptions and experiences of immigrant workers with different cultural backgrounds in Finland of occupational health services. The aim of the study is to increase understanding about occupational health services for clients with diverse cultural backgrounds. I intend to interview 10-15 employees with foreign backgrounds in Finland. During these interviews, questions will be asked related to your perceptions, expectations and experiences of occupational health services. The results of this study will be presented to the University of Tampere and feedback be sent to participants. The results could be used to improve health services for immigrant workers. The interviews will be conducted in the months of July and August 2014. The interviews will be recorded with the permission of the participants but will be later erased after use. The participant's identity will remain anonymous throughout the study. Please feel free to contact me without hesitation about any question(s) that may arise concerning this study.

Thanks in advance for your cooperation and participation.

Yours sincerely,

Leonard Apondi
University of Tampere
School of Health Services
Email: Apondi.Leonard.O@student.uta.fi
Tel: +358-452770087

Supervisor:
Pirjo Lindfors
University lecturer (Public Health)
School of Health Sciences
University of Tampere
Email: Pirjo.Lindfors@uta.fi
Tel: +358 40 190 1688

Appendix 2

Research interview questions

1. Background information

Sex: Male/Female

Age: a) <25 years b) 26-30 c) 31-35 d) 36-40 e) 41-45

2. What is your nationality?

3. Marital status: a) Married b) Single c) divorced d) co-habiting e) separated

4. What is your level of education?

a) High school b) Vocational school c) Graduate d) others, what?

5. When did you move to Finland?

6. Could you briefly explain what type of work experience you had in your own country?

7. What is your work history in Finland?

8. Briefly, describe your current employment and the nature of your work contract?

9. How many languages do you speak?

In a scale of 1-5, how do you rate your Finnish language skills?

10. What do you know about occupational health services?

11. What expectations do you have of occupational health services?

12. Briefly, could you describe your experiences of occupational health services?

13. What would you describe as your best experience of occupational health services?

14. Have you ever had any bad experience with occupational health services? If yes, could you briefly describe how it was like?

15. Do you have any suggestions to make to improve the services?

16. What other general comments do you have concerning the services?

17. Is there anything else you would like to discuss concerning the services?