

ORIGINAL ARTICLE

Experiences of health and care when growing old in Norway - From the perspective of elderly immigrants with minority ethnic backgrounds

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Abstract

Background: Along with the growing population in Norway of older people with immigrant backgrounds from countries in Asia, Africa and Eastern Europe there is a need for a better understanding of trans-cultural aging, illness experiences and care preferences among minorities and their families.

Aim: This study explored older ethnic minority immigrants' experiences of growing old in Norway with a focus on health and care.

Design: An explorative, descriptive design with a grounded theory approach was used.

Method: The data was collected in Norway by means of open-ended interviews with nine ethnic minority immigrants representing an age span from 63 to 85 years. In total 15 interviews were conducted, with the sampling, data collection and analysis carried out simultaneously and guided by the constant comparative method.

Results: This study showed that the most important issue when growing old in a new homeland as an ethnic minority immigrant was to be surrounded by one's family. When the needs for care increased due to changes in age and health, the family was seen as the only possible solution. Feelings of fear and distrust, language barriers, and preferences for the familiar care were reasons for this. Due to cultural rules it was taken for granted that the younger generation took on responsibility for their older parents/relatives in need of care, which led to feelings of dependency and being a burden. A high price had been paid for finding a new homeland.

Conclusions and Implications for Practice: The elderly immigrants' expectations of care was found to be strongly connected with traditions from their native country, where it was taken for granted that the younger generation took the responsibility for their older parents/relatives in need of care. Our findings highlighted the dilemma of culturally determined controversies, as elderly immigrants' beliefs and values about care within the family may be rather difficult to unite with a life in a new Western society. Nursing practice needs to implement a more family-oriented care perspective in order to meet the needs of elderly people with ethnic minority and immigrant backgrounds. Further it is important to increase elderly immigrants' feelings of trust and cultural safety towards health-care services.

Key words

Care preferences, Elderly immigrants, Ethnic minorities, Grounded Theory, Transcultural ageing

1 Introduction

Through globalization and immigration from different parts of the world, Norwegian society has become more and more complex and diverse. Along with a growing population of older immigrants from countries in Asia, Africa and Eastern Europe there is a need for a better understanding of trans-cultural ageing, illness experiences, and the care preferences of older minorities and their families. Authorities have recently shown a growing interest in the situation for older immigrants, and how the care services best fit their needs ^[1-4]. These reports have stressed the need for knowledge development concerning older persons with minority ethnic backgrounds and their families' health and care in Norway.

Cultural diversities in relation to language, religion, dietary preferences, family structures, and beliefs related to health and care have impact on care-giving situations ^[5,6]. There have been several studies carried out from the caregivers' perspective which show that language obstacles are perceived as the main barrier to the contact between older immigrants and the health- care system. Nurses have described that many later-in-life immigrants only speak the language of their native country, though despite this, professional interpreters are seldom used in the care of older foreign-born patients ^[7,8]. Few studies have been found that illuminate older immigrant patients' perspective of their health and care in the Nordic countries. Heikkilä and Ekman found in their studies that continuity in care and feelings of safety and togetherness were the factors of greatest importance in care situations for older Finnish-born immigrants in Sweden ^[9,10]. Shared customs and popular culture were described as common grounds for enabling caring relationships. In a study about older Bosnians in Sweden, Hadziabdic and Adatia-Sandström ^[11] found that many Bosnian customs and traditions were abandoned, thereby causing feelings of insecurity, a lack of comfort and a deterioration in health and wellbeing. In two Swedish studies, Emami, Torres, Lipson & Ekman ^[12] and Emami, Benner & Ekman ^[13] have investigated older later-in-life Iranian immigrants' strategies for promoting health and preventing illness, and based on their results, a socio-cultural health model for later-in- life immigrants was developed that illustrates the complexity of the relationship between sociocultural determinants and experiences of the meaning of health. In the context of Norwegian health care, no previous studies have been found that emphasize the views of elderly immigrants as being related to ageing, chronic disease management or culturally patterned care beliefs and practices. Hence, the aim of this study was to explore the experiences of growing old in a new society with a focus on health and care.

2 Method

The study had an explorative, descriptive design. Since there had been little previous research in the context of Norwegian health care focusing on ageing immigrants with minority ethnic backgrounds and their experiences of health and care, grounded theory was considered as an appropriate method ^[14].

2.1 Setting

The study was conducted in a middle-sized, non-urban municipality in Norway with a total population of approximately 28000 inhabitants. The area was mostly rural with a few small towns, and the population had been primarily ethnically homogenous for many generations, though over the past 10 years the number of inhabitants with a minority ethnic background had increased. Many new inhabitants from distant countries had settled as refugees due to political upheavals, wars and humanitarian crises in their native countries, and a total of 2059 inhabitants (7.1%) had backgrounds from countries in Asia, Africa, South- or Latin America and European countries outside the EU /EEA ^[15]. The country classifications "Western/non Western" is no longer in use by Statistics Norway, who has overall responsibility for official national statistics, and carries out extensive research and analysis activities. Statistics Norway now classifies countries according to continents as referred to above.

The Norwegian community health care system has a mixed model of family care and welfare state provision ^[16]. The public community health care system provides home nursing, institutional care and social services ^[17]. Public health care, both community services and hospital care at the state level, is supposed to be equally accessible to all legal residents in Norway, regardless of their incomes. Universal public health care is financed by the states' tax revenues and a national insurance scheme.

2.2 Participants

The participants were recruited in collaboration with general practitioners, community health nursing services and local refugee service, and both oral and written information about the study were provided to doctors, nurse managers and social workers. The participants were purposefully included according to the following criteria: being an immigrant from a non-Western country of origin, as described above, being age 60 years or older, having an ability to understand and speak Norwegian, and being permanently settled as legal residents in the municipality. The participants also needed to have had experiences of illness, and been willing to articulate their experiences and expectations of health and care in Norway. If they were willing to participate, the first author contacted and informed them verbally about the purpose and procedure of the study. They were also informed that a relative or significant other person, who spoke both their mother language and Norwegian, could attend the interview as a support. The number of participants was not decided in advance according to grounded theory ^[14], and nine participants, including seven women and two men, from Iran, Iraq, Vietnam and Bosnia-Herzegovina were included representing an age span from 63 to 85 years. Two men and one woman were married and lived together with their husband/wife, and six were widows of whom four lived alone, and two lived with a son/daughter and their families. They had all been legal residents in the municipality for 6 – 20 years, with a median resident time of 16 years in Norway. Eight participants had a median age of 60 years when leaving their country of origin and settling in Norway, while one participant was 47 years old at the time of migration.

The migration reasons ranged from escaping war, political and religious reasons or both. Moreover, all of them had come to Norway in order to be reunited with younger family members. All of them suffered from different health problems and illness such as diabetes, hypertension, heart failures, cancer, muscle pain, depression, sleeping disorders, dizziness and reduced hearing and sight, and maintained regular contact with a physician. Only one received some help from domestic public home care services, one received some community nursing care (medication distribution and wound care). All the participants had extended help and care from family members.

2.3 Data collection

The data collection and concurrent analysis were carried out between March 2008 and December 2009 by means of open-ended interviews, two interviews with six participants and one with three participants, with a total of 15 interviews being conducted. The intention was two interviews with all participants, but due to sudden illness the second interview was impossible for two participants at the actual time of the study. One participant did not wish a second interview as this person thought that everything had been said in the first interview. The interviews lasted for approximately 90 minutes for the first interview and one hour for the second, and took place in the participants' homes in the presence of a family member or significant other person. The interviews were conducted in a conversational style in which the participants were asked to talk about their experiences of health and care in relation to ageing in Norway. All the interviews were conducted, tape-recorded and transcribed verbatim by the first author (BT). In all interviews Norwegian was used, but due to language difficulties, English could occasionally be used when problems in understanding occurred. When necessary, a bi-lingual relative or friend who spoke more fluid Norwegian was present and could act as an interpreter. The interviewer had to be very sensitive to semantic and rhetorical aspects during the interviews, and probing and follow-up questions were constantly used to assure an understanding of the full meaning. Despite the language difficulties, a dynamic and trustful rapport developed between the participants and the interviewer, thus leading to the participants sharing their experiences, feelings and reflections. The data collection proceeded until the new interviews did not provide any additional information and saturation was considered to have been reached.

2.4 Analysis

The data collection and analysis were jointly done, and guided by the constant comparative method as described by Strauss and Corbin ^[14], meaning that the growing understanding of the data guided further data collection. The systematic coding processes began with an open coding of the text from the interviews, and initial codes that captured the meaning and process of data were applied. Codes with a similar content were then assembled into preliminary and more abstract categories. During the following axial coding, categories were reassembled to form a more precise and complete explanation. By constantly asking generative questions about causes and consequences, conditions and contexts, connections between categories were uncovered and linked together. In the selective coding process, each category was saturated with information from new interviews or from earlier assessed data, and a core category was identified. This included confirmation or rejection of relationship between categories. During the entire study memos and theoretical notes were written by the first author in order to enhance the process of abstraction and conceptualization. This also contributed to formulating a conceptual model that could describe elderly immigrants' experiences of growing old in a new society with a focus on health and care. In order to strengthen the validity of the findings, all the researchers worked in close collaboration during all steps of the research process.

2.5 Ethical considerations

The study was approved by the Regional Committee for Medical Research Ethics in Norway, (Project no. 148-05-04274, 2008), and carried out according to International Council of Nurses' code of nursing research ^[18] which takes principles of confidentiality, voluntariness and the integrity of the participants into consideration. The project was also reported to the Norwegian Social Science Data Services (Project no. 14274, 2008). All of the participants were informed both verbally and in writing, and signed a consent form before the data collection started.

3 Findings

During the analysis, one core category and three categories emerged from the data. The core category labelled 'Embedded in the family when dealing with transitions' was reflected in three interrelated categories: Withdrawal from the new society, From reliance to burdensome dependency, and Awareness of paying a price (see Figure 1).

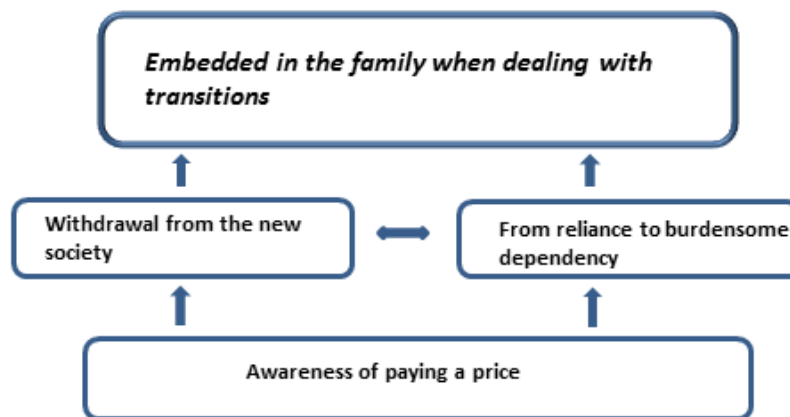


Figure 1. Description of the meaning of getting old in a new homeland with focus on health care

3.1 Embedded in the family when dealing with transitions

The core category describes the older immigrants' struggles and main concern: to remain safely embedded in the family, and constantly attended and cared for by family members when dealing with demanding transitions. These transitions

were related to cultural shifts as well as changes in age, health status and the need for care and help in daily life. The experience of health and well-being was unquestionably associated with the family setting. Although all of the participants knew about geriatric health-care services in Norway, most of them would not or could not see themselves as receivers of public home care or institutional care. The reasons had both cultural and language dimensions as the participants' normative ideals of health and care were rooted in family-oriented values which meant that when being old and ill in a new homeland, the family was seen as the only 'anchor', and the younger family members were expected to take on the role as caregiver. Limited social and communication skills were described as great obstacles to social interaction with people outside their own family, which was also the case in relation to contact with professionals in the health-care services.

3.2 Withdrawal from the new society

This category describes the participants' insecurity towards the society outside their homes, thereby bringing about unobtrusiveness and withdrawal. Some participants described strong feelings of fear and distrust in front of unknown people, and for them being as invisible as possible were necessary in order to avoid risks and problems. As one participant put it:

'As long as we are at home, we don't bother anybody. We are comfortable at home.'

This withdrawal could also be dependent on a desire to remain in an already known and familiar environment, in which safety, recognition and satisfaction can be found. Therefore, social interaction was only sought within their own cultural group. When the participant lived in a rich social network this withdrawal was described in positive words, but with a reduced or unstable social network the withdrawal impacted negatively on their experiences of well-being, since it led to loneliness.

All of the participants lived in a rather small social circle of people from their native country, consisting mostly of close family members. They lived as 'an extended family' despite living in different dwellings and spent most of their time together with children and grandchildren. For one participant, whose son had left Norway some years ago with his family, a couple and their children from the same country of origin substituted for the family. Their social life was described as much better in the previous homeland than in Norway, since older people there could also have a rich network outside the family.

A poor ability to speak Norwegian was perceived as a great hindrance for social interaction with individuals outside their own cultural group:

'It is difficult as you get older, the language. And you have the difference between you and us. It is best to make it on our own, and not bother anybody. I don't like being dependent upon others, who are outside of the family. Then it is better to speak together in the same language. I end up sitting there alone, having to be accompanied by my daughter. For her, there will be even more to do if she has to go out with me.'

The participants told about a close contact with relatives who were still living in their old home land, with these narratives describing experiences of longing and sorrow as a part of being old in a new homeland.

3.3 From reliance to burdensome dependency

This category shows the participants' thoughts of being dependent on the younger generation of the family, which had two dimensions: being reliant versus being a burden. All the participants described the cultural 'golden rule' that when growing old younger family members would provide the needed care. Changes in their own situation related to increasing health problems and extended care needs had led to worries about the future, as the new country had no room for family care in the manner they were used to. Most of the participants described themselves as strongly dependent on their families

in regard to the activities of daily living. The help was provided by daughters, daughters-in-law, sons, grandchildren or close friends, in cases of an absent family.

One participant said:

I need help from my family. My daughter does everything for me and that is natural for us. You see, I cannot and will not get assistance from anybody outside of the family. It wouldn't work anyway. They don't understand me and my life. And I can't make them understand because I don't speak their language. My daughter will always help me, whatever happens.

Most participants were fully aware of and worried about the physical and mental burden, particularly on daughters and/or daughters-in-law, but sometimes also on sons, who took on a considerable amount of responsibility for the care of parents and/or parents-in-law. A growing insight was revealed insofar as the changes in the society also threatened the family-centered value system. Since their own children were the second generation in Norway, they were a part of the modern Norwegian way of living, which meant that younger female family members were joining the workforce and taking higher education. With this change, a weakening of the sense of obligation to support old family members followed:

I feel alone and worthless. I sit here crying. I totally depend upon my children. I have to know when they can come, but I don't like to ask all the time, knowing how busy they are. They have their children and demanding jobs. I can't call them all the time.

An underlying worry was found in terms of being dependent on younger family members meant increasing feelings of a lack of safety. Despite this, all the participants expressed a desire to stay with the traditions from their native country, and to be cared for by the family when they were unable to care for themselves.

Some of the participants told about how they consulted physicians when visiting the countries of origin. They bought drugs and other medical supplies 'at home' not trusting the services in Norway.

In addition to the cultural reason for a dependency on family members and unwillingness to accept health care from the society, was the language problem and the experiences of lack of time from nurses. The participants also thought that nurses were lacking in an understanding and knowledge about their culture of origin. Responses indicated that the participants expected nurses to be polite, respectful and willing to listen, to be able to understand the participants' 'lived life', be interested in the participants' life stories, and understand the consequences of migration. As one of the participants said:

There must be someone who realizes that life is not easy, and that everything is different in Iran compared to Norway.

The participants described that the health-care personnel they had met had consistently spoke to the younger family member, accompanying them, instead of them excusing this behavior as the younger family member simply 'speaking the language better and faster than me'. Moreover, the regular contact and communication with the physician was carried out through the family member who was always attending the consultation.

3.4 Awareness of paying a price

This category shows the participants' awareness of the price they had paid for their migration to Norway. They described many losses and difficulties as well as physical and mental hardships related to their migration and the subsequent time after. This price was talked about as interrupting a wide variety of relationships and breaking with an entire culture, and then trying to maintain parts of it within their own home together with their family and friends from the same country of

origin. The stories about the migration were colored by selflessness; all of the participants emphasized that the migration was done for the sake of their children and grand-children:

It is better here, fewer problems and no poverty. Nobody hunts you. The children receive an education and good jobs. We came here for them, for their future.

In exchange for all the losses and negative experiences, they received pride and joy in their new way of life together with their family. They considered their grandchildren to be fully integrated into their new society, and they spoke proudly about them being bi-lingual, and finding happiness in teaching them about the customs and traditions from their native country, as well as learning Norwegian from them. The emphasis was on the grandchildren's adaptation to and integration into the Norwegian way of life though a consequence of this integration was the loss of care-taking traditions within the home.

4 Discussion

In this study, being surrounded by one's family was found to be the most important issue when growing old in a new homeland as an ethnic minority immigrant. When facing different transitions, not only related to cultural shifts, but also concerning changes in age and health, increasing the needs for care, help and support from the family was seen as the only possible solution when problems related to health and care occurred. The reason for this was found to be strongly connected with traditions from one's native country, where it was taken for granted that the younger generation took the responsibility for their older parents/relatives in need of care. This demand for a strong obligation to care for family members has previously been described as fitting within the concept of 'familism', with a meaning of 'orientation towards the well-fare of one's immediate and extended family' [19, p. 461]. This concept has its roots in traditions that nowadays mostly remain in non-Western cultures. Our findings illuminated that implementing this type of 'familism' in a new Western homeland led to a withdrawal from the new society as well as to feelings of loneliness and being a burden.

The participants described how they comprehended and managed their situation within their small family circle, though in so doing they lost out on an active social life and the opportunity to be integrated into their new homeland. As a result, they were missing the kind of life that older people 'back home' had, insofar as being socially active and included in most parts of daily life even when being ill or immobile. Several studies have argued that an active social life is associated with good health and well-being among older people [20, 21], including an expression of 'togetherness versus being an onlooker' as described in a Swedish study of older people dependent on community care [22]. The older immigrants in this study appeared to be unobtrusive and withdrawn 'onlookers' in regard to the new society. Feelings of fear and distrust towards un-known people were reasons for this, while others were the language barriers, and their preference for the known and familiar. Older immigrants' experienced feelings of being in-debt to their new society, while at the same time being left on the fringes, living with the experience of severe losses, feelings of homelessness and a sensation of not having any future, all of which has been described in previous studies [23, 24].

For the participants in this study the future was their children and grandchildren, and they associated their hopes and wishes solely with them. They were proud of the younger generations who had succeeded with their integration, but were also well aware of the price they themselves had paid for giving their children a better future. Except for visiting the physician the participants in the present study strongly rejected contact with the community health-care program, although they also expressed uncertainty and worry about how long their families would be able to take full responsibility for them. As described in our study, the participants were well aware of the considerable responsibility the younger generation took for their care. They also realized the heavy burden their need for help put on their young relatives, as this made it difficult for them to fully take part in society with full-time work outside the home or education. Taking the perspective of the younger family members on the question of caring for an older relative, who was refusing community care, it is easy to understand the stressful situation that could occur [25]. This type of stress may be seen as a kind of

acculturation stress, taking place in relation to adjustments to cultural changes^[26]. As acculturation stress has been found to also generate stress in other family members^[27], the need for incorporating a family system perspective in the care of this group of older people is obvious^[28].

The participants in our study stressed that respectful, interested, listening, caring and empathetic nursing personnel was a necessity, if they would even think about using the community health care services. These expectations are well in accordance with models and research findings about the adequate behavior of nurses in transcultural nursing, which encourages a caring relationship that helps to establish a good rapport^[29-31]. Health-care personnel can never compensate for the losses experienced by the older immigrants, though their feelings of loneliness and despair may decrease by nursing interventions focusing on social inclusion and togetherness. Even so, Cortis^[32] found that nurses had difficulties in linking culture and spirituality to care, in order to meet the needs of minority ethnic patients. The importance of avoiding stereotypical thinking when encountering patients, especially for those who do not share the traditional majority culture, is highlighted by Brämberg^[33] and Kulwicki, Miller & Myers Schim^[34]. Simply having knowledge of specific cultural beliefs, traditions and practices in and of themselves is far from sufficient for developing essential caring skills^[35, 36].

Our findings demonstrated that not only differences in culture and habits but also difficulties with language, were obstacles for using community health care which is a well-known problem reported in many studies^[8, 37-39]. Understanding a new language is essential for comprehending information about the health-care system and hence what to expect from it. Therefore, the strong resistance expressed by the participants in this study against community health care may have been caused in part by misunderstandings and a limited knowledge of the Norwegian health care system due to language difficulties. The complexity of a Western health-care system can be far from what they were used to in their former homeland^[40].

In a Norwegian study, Goth, Berg & Ackman^[41] found that Regular General Practitioners (GPs) focused on socio-cultural difference rather than legal status, which often obstructed the doctor-patient communication and understanding. In dealing with the public health services the GPs experienced that immigrants seemed helpless because of differences in expectations, a systemic failure to co-ordinate care, and language difficulties. A later study with migrant patients as informants^[42] is well in line with this, thereby showing that the pattern of doctor-patient interaction, conflicting ideas about the role of the doctor, and language and cultural differences hindered the patients' use of the GP services.

To overcome language difficulties and avoid misunderstandings, family members were used as translators, when the participants in our study were visiting a physician. This is in accordance with what Gerrish and co-workers^[43] reported, and they also found that professionals in health-care were reluctant to use interpreters in the encounter with minority ethnic groups. Even if the presence of family members is important for supporting older immigrants in their contact with the health care system^[44], the utilization of professional interpreters is also of utmost importance^[37]. However, Gerrish et al.^[43] have highlighted that both nursing personnel and doctors need training in how to collaborate with interpreters, so the communication can run smoothly between the triad of patient, professional and interpreter. Other ways to aid communication with minority ethnic groups in health care has been described such as including family members who can translate and write down usable words and phrases^[44], or using multilingual staff in nursing homes^[45]. Samarasinghi and co-workers^[28] suggested a family-focused care with a supportive conversation with the members of the family as a means of improving the care of immigrants. This was seen as being particularly important in cases of family reunification when family members could be in different stages of the cultural transition. Even if some of the participants in our study had arrived to their new homeland many years ago, it was obvious that the acculturation process was still taking place. Our study showed that the health-care system faces a major problem if this group of people and their families are allowed to resist in their rejection of community care services. Consequently, the key question to address is how to improve the older non-Western people's feelings of trust and cultural safety^[46, 47] towards community health-care personnel.

Methodological considerations

In this study, immigrants from different countries were studied as if they all had the same culture of origin, and what connected them were old age, health problems and experiences of migration. To describe their experiences and expectations of health care may be seen as a crude generalization between populations^[32, 48] which must be regarded as a limitation of the study. However, to focus on one ethnic group and the principle of a theoretical sampling of the participants^[14] was not possible because the process of acquiring entry into the field turned out to be particularly demanding. The number of presumptive participants was limited, and many rejected participation for various reasons, although mostly due to illness or language problems. Open sampling was therefore continued throughout the entire data collection process, including with all available participants. The participants included in this study thus represented a varied sample of older immigrants. Taking the limitations into consideration, transferability to one special ethnic group must be done with caution. Due to the rather few participants it was not considered relevant to discuss the data related to variables such as gender, age and the time from immigration.

Interviews were considered to be the best data source for providing insight into how older non-Western immigrants experienced their situation in relation to aging, health and care. However, the data collection had some limitations. The interviews were conducted in Norwegian, which was the participants' second language, thereby most likely negatively influencing their opportunity to tell about their experiences and thoughts. Nevertheless all of the participants' had the ability to understand and speak basic Norwegian, and were talkative and willing to share experiences. The impact of having a family member present, who in some cases acted as an interpreter during the interview, must also be taken into consideration. For some participants, this was a prerequisite for participating in the interview to help provide a sense of security, although the presence of a family member may have exerted an influence on the answers. A family interview may have been preferable considering the close relations within the family^[49], as interviewing the entire family may therefore have yielded a deeper and more complete picture of health and care about being old in a new society. The best way to really capture the immigrants' experiences would have been to use an interviewer with the same language and cultural background^[24, 45]. This would give an opportunity for all available immigrants in the group under study to be heard on this issue. To include only Norwegian speaking elderly immigrants might be seen as an ethical shortcoming. An important aspect to validating the data for this study was to rephrase the questions in order to create meaningful ways of achieving a mutual understanding between the older immigrant and the interviewer, hence seeking to avoid misunderstandings. Another way to ensure and deepen the participant's story was to interview the same participant on two occasions. Unfortunately, three participants, two women and one man, declined to do the second interview, though for ethical reasons no further inquiry was made.

5 Conclusions

The participants in the present study strongly rejected contact with the community health-care program, as issues related to health and care were considered to be a family concern. Their life situations were experienced as isolated and distant from society, and a high price had been paid for their migration to a new homeland. Primarily relying on the family often implied a dependency for themselves being a burden on the younger generation of the family, who were hindered in their partaking in the society. As a result, our findings highlighted the dilemma of culturally determined controversies, as older immigrants' beliefs and values about care within the family may be rather difficult to unite with a life in a new Western society.

Clinical implications and further research

For older immigrants, struggling with language difficulties and limited social skills, contact with people outside the family should be offered, e.g. through invitations to spend time at day care centers. The initiative should be taken from health-care professionals, in order to focus on health promotion, and the older immigrants' quality of life in addition to providing support to the families. One focus should be on how to increase older immigrants' feelings of trust and cultural safety

towards health- care services in Norway. Moreover, attention should also be given to the managerial and educational responsibilities related to the growth in groups of older patients with a different cultural background than that of traditional Norwegian. The implementation of a family system perspective in public care services is needed in order to meet the needs and expectations of minority ethnic families.

The effects of extended family care-giving among minority ethnic immigrants as experienced by younger family members has not yet been studied in a Norwegian health-care context. Further research is therefore needed that focuses on experiences among family care-givers within multi-generational immigrant households. Other topics for further research would be how to best train and supervise nursing personnel to help them develop the cultural competence and sensitivity needed in the care of minority ethnic patients.

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