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Challenges with Collectivistic Culture in-Home Care Reablement

- A qualitative study

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Prefaces

The work on this master´s thesis has been a long and demanding process. There has been times where I doubted myself if I would ever come to be finished and come to a result too. But it has also been an exciting and educational process. I have acquired amount of knowledge about the study I chose and the research process.

I would like to take this opportunity to thank my supervisor Associates Professor Marte Feiring, who has contributed constructive feedback and advice along the way throughout the process. I would also like to thank you for enabling me to do my studies with my health challenges and thank you for introducing me with interesting literature in my research area. It has been very important for my assignment. Furthermore, I would like to thank my first supervisor Professor Inger Marie Lid who had to withdraw from the task process due to other obligations. I have greatly benefited from your help too in the beginning.
I would like to give my big thanks to my informants who shared their valuable experiences with me. Without that, this task could not be achieved. Last but not least, I would like to thank my two beautiful daughters Isma and Bilan who have been there from the beginning. They are my inspiration for this task.

Forord

Arbeidet med denne masteroppgaven har vært en lang og krevende prosess. Det har vært tider hvor jeg tvilte meg selv om jeg noen gang skulle bli ferdig og komme til et resultat også. Men det har også vært en spennende og lærerik prosess. Jeg har fått mye kunnskap om studien jeg valgte og forskningsprosessen.

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Sist men ikke minst, jeg vil gjerne takke mine to vakre døtre Isma og Bilan som har vært der fra begynnelsen. Dere er min inspirasjon for denne oppgaven.

Innholdsfortegnelse

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Summary

Purpose : The aim of this study is to investigate the challenges that health professionals face in rehabilitation with Adults' minorities in home care reablement and how these experiences can be understood.

Background: The study indicates there has been an increase of immigrant in Norway, due to labour immigration from the EU's new member states east of Europe, and to the many refugees who have found their way to Norway due to war or poverty. Meeting this group of people from different culture with lots of family involvement in clients' rehabilitation, limited knowledge about their health and public information about rehabilitation has and is challenging for health professionals.

Method: Qualitative method has been used to answer the study's research questions. Semi-structured interviews were carried out with six health professionals. The sample consisted of 2 physiotherapist (both were Norwegians), 3 were occupational therapist (one Norwegian, one from Bosnia and one from Zimbabwe) and 1 nurse from Somalia. A systematic text condensation that consists of four steps was used to analyse the raw data.

Results (analyses and discussion): The health professionals identified several features of the challenges they face in home care reablement that they believed affected the rehabilitation of adults´ minorities. These were diversity culture, interdependence, expectation on recovery, problematic with goal setting and cultural awareness.

Conclusion: It appears to be a need for increased multicultural competence and more people with minority backgrounds in health and social services with better prerequisites for understanding the cultural and religious background of adult´ minorities.

Key concepts: Culture, health, goal setting, cultural awareness, rehabilitation and home care reablement.

1.0 Introduction

1.1 Background for theme selection

My field of interest is health professionals providing rehabilitation to adult' minorities in home care reablement.

In home care reablement, rehabilitation takes place at clients home. It offers opportunities to facilitate activities and participation in one's home environment. Almost all minorities clients live with their extended family, this being part of their culture. This may be even more challenging in the context of home care reablement, since the adult´ minorities´ families desire to look after their client. This might aim to enable participation by simply providing traditional help and care. One thing is that this is their home and one has to expect that the families have the power to decide for the clients. This can be part of their culture and may be the clients' wishes.

In the last ten years, the number of immigrants has gone up. Debasy and Slettebø (2012) state that figures from the Norwegian National Agency (2010) show migration rates in Norway has increased year by year, and it shows that the people living in Norway who immigrated themselves or were born in Norway with immigrant parents is approximately 12.2 percent or 600,900. The reasons for immigration are different (Solvang and Slettebo, 2012 page 128). We see that this number of immigrants has gone up since 2012. According to SSB (2018), the standard characters table shows an increase of immigrants. Norway had 746661 resident this is primarily due to labour immigration from the EU's new member states east of Europe, and to the many refugees who have found their way to Norway due to war or poverty.

Health professionals face many challenges in relation to this group and will face more of it in the future trying to adjust their services to these different cultures in health sectors. Meeting this group of people from a different culture with lots of family involvement in clients' rehabilitation, limited knowledge about their health and public information about rehabilitation, social stigma and the public invisibility of disabled people from their society and difficulties identifying meaningful goals for rehabilitation is a big challenge. These challenges will be able to influence health professionals by creating new work situation, but at the same time the challenges will enrich health professionals. So, management of clients with minority backgrounds are relatively a challenging problem and more knowledge and

awareness is needed. One way to understand culture can be "the knowledge, values and patterns of action people acquire as members of society" (Magelssen 2008: 15).

It is hard to implement the Norwegian idea of how rehabilitation should be undertaken for this group of clients. Minority, clients come from heterogenic society, where they have a culture, of interdependence. Rehabilitation practices are established for western cultures and do not always match with adult minorities' culture. This creates uncertainty and insecurity for them. Health professional strive to help these clients to achieve the best health status and to have a certain degree of self- independence in relation to their impairment. Adult minority clients should be seen as unique individuals with their distinctive needs, desires and people who have by virtue of their association with a particular culture or religion. It is also important for the ethnic minorities to integrate within the Norwegian culture system.

1.2 Why I am motivated to write this assignment?

My interest in this topic was awakened during my work with minority clients for over five years in a rehabilitation institution. They were patients who had a stroke, fracture of the hips or arms or broken legs, all sorts of diagnosis that was the course of their impairment. And they were from different countries with different cultures and believe. It was hard to implement what the Norwegian idea of how rehabilitation should be or implementing self-efficacy and setting their own goals in order for them to get the best outcome. Health personnel strive to help these patients to achieve the best health status and to have a certain degree of self- independence in relation to their impairment. There were a lot of challenges that health professionals meet every time they tried to rehabilitate this group of clients. Due to culture and belief indifferences it was very easy to have prejudice thought towards this clients. Some health professions came to quick conclusion that the minorities' clients were simply lazy to engage them selves in their rehabilitation. Others thought it was due to family always being around them, that practically did everything for the clients. In my study most of the health professions had ethnocentrism approach when they meet these challenges. It caught my attention that a study of minorities in home care reablement was needed.

1.3 From theme to a research question

It has been an exciting journey from theme to finding a research question. I was initially interested in focusing on adult minority in reablement because, in my opinion, this group is

most vulnerable. They have lived a life filled with challenges before they emigrated from their homeland to establish themselves in a foreign country with a new culture, new surroundings and a different health system approach. This can be also challenging for the minorities clients too.
After studying this phenomenon, I found that in Norwegian society research over the last twenty years, have had an overwhelming focus on the integration of minorities, but there is very little research that indicates something about adults´ minorities in home care reablement. This aroused my interest in this theme even more.
The selected topic for study is:
" What is the challenges that health professionals face in rehabilitation with Adult minorities in home care reablement and how this experiences can be understood"?

Sub-question questions related to this issue that I have chosen are:

1.What can health professionals do to provide help based on an understanding of adults minorities culture?
2. What reflections do health professionals have about adults' minorities' expectation when it comes to rehabilitation?
3. What experiences do health professionals have when it comes to challenges adult minorities encounter achieving goals in rehabilitation?

I choose to limit the research question to deal only with health professionals that have worked with adult minorities who are not born in Norway and are receiving rehabilitation in home care reablement. According to the informants very little of religion, particularly Islamic beliefs is, mentioned in the interview. So I intend not to go deeper into religion but a little will be mentioned in theory and in discussion. I have used the terminology adult´ minorities in my study where I refer to minorities that migrated to Norway in their adult age. They have migrated from different countries such as Afghanistan, Pakistan, Somalia, Siri Lanka, Nigerian and many other countries. It would also be interesting to research on how ethnic minorities relate to their body and self in relation to their culture. But due to the extent and time of the assignment I had, it was impossible to do such a comprehensive study.

1.4 Why is this knowledge about adults 'minorities' in home care reablement in Norway important?

There are many reasons why it is important to have knowledge of challenges that occur in the rehabilitation of adult minorities in home care reablement. Health professional workers meet clients with different ethnic background, and can create uncertainty if they have little or no knowledge of their culture, being and mind set. This will mean major challenges for the reorganization of the care services of this group. In order to provide comprehensive rehabilitation and to meet their needs, it is, therefore, necessary to have knowledge of these clients and the matters that are important to them. It will also contribute to our knowledge about an area for development on cultural competence. It will also promote a cultural relativism approach, which can produce, a better outcome for these adults.

1.5 Clarification of concept

1.5.1 Minority

Ethnic-minorities are a collective term for both immigrant backgrounds and national minorities. The term ethnicity derives from the Old Greek term ethnikos / ethnos which originally means heathen, but later it refered to people (Eriksen and Sorheim 2003). The term often refers to different groups of people with common culture and country affiliation/nationality (Phinney, 1998). Ethnicity is also used to refer to cultural syndromes that are patterns of attitudes, values, norms and behaviours (Torgersen 2005: 11).

1.6 Structure of the assignment

The further development of the assignment will be as follows:

• In chapter two, I present previous research studies that I have used in my studies.

• Chapter three presents the theoretical frame of reference for the study. Here, I have explained what is culture, the difference of collectivistic and individualistic culture, ethnocentrism and cultural relativism; cultural awareness, cultures and health, rehabilitation and home care reablement. I will explain the theory around goal setting work in reablement

and goal setting in collectivistic culture. I will also look into how selected factors play in and we will associate this with the concepts of trust and communication. A little bit of information on religion and family involvement is included.

• Chapter four presents the choice of research method and the study procedure. Thereafter, methodological critique and considerations follow the reliability and validity of the study, as well as ethical considerations.
• In Chapter five, the results of the analysis are presented in this chapter study with a subsequent discussion of the results against current theory.
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• In Chapter six, summarization of the results and the relevance of the study to the subject field are covered. In conclusion, areas that are considered relevant for further research are pointed out.

. Chapter seven is references used in my studies.

2.0 Previous research

In this chapter I will present earlier research studies that I have been inspired by in my study. I would like to point out that there is little research-based knowledge in the field of minorities in home care reablment. To survey current international research on minority families with disabled children, I have done systematic searches in Medline, PubMed and Oria. The keywords I used were collectivistic/individualistic, rehabilitation and minority. In addition, I have used the reference lists in current literature as an information source.

I identified three different research work which each has a different focus in rehabilitation, individualistic/collectivistic on goal setting and cultural effects of training. The first qualitative article is rethinking rehabilitation´s assumptions by Karen Hammell (2015). She reflects this work on her earlier studies on rehabilitation, including the term ´cultural imperialism´. The second one is a qualitative article; cross-cultural issue in goal setting written by Edwin A. Locke and Gary P. Latham (2002). The last one is a quantitative article "self or group: Cultural effects of training on self-efficacy and performance" written by P Christopher Earley (1994).

2.1 Rethinking Rehabilitation`s Assumptions: Karen Hammell

According to Hammell (2015) rehabilitation´s assumptions and practices ought to be evaluated and rethought. She emphasizes that the rehabilitation literature reveals several common assumptions, such as the nature of the therapy professions and the nature of their goals. Her discussion about the theory of advancing rehabilitation knowledge, unearthing important questions for policy and practice, supporting research design are, and persuading readers to question clinical assumptions.

Challenges assumptions about normality as a goal, challenges assumptions about physical function and quality of life and challenges assumptions about physical independence and quality of life are also presented. The assumptions mentioned give the efforts to rethink and re-examine rehabilitation´s assumptions and theories. And also whether the rehabilitation interventions are aiming at the right target.

Hammell (2015) defines rehabilitation as a process of enhancing engagement in living and of assisting people to live well with their impairments in their own environments. She has also

suggested that rehabilitation professionals ought to take seriously the idea that ability is of little use without opportunity. She also proposes in this chapter how to rethink core processes in rehabilitation, such as goal setting, teamwork, communication with clients, and outcome measurement. How to rethink rehabilitation services and interventions might better 'fit' clients and address what matters most to them and their families and how to rethink research designs, considering how to enhance the understanding of the "why" behind the findings (Hammell, 2015).

Further a definition health and recovery is defined. A definition that, Hammell (2015), claims to be within rehabilitation. Health is defined as the ability of an individual to maintain a sense of integrity as productive, able and valued individual despite their physical condition and within their social spheres. And recovery is defined as the process of changing one´s attitudes, values, goals, of living hope, satisfying, meaningful, purposeful and contributing life within limitations caused by one´s disease or impairment.

Hammell´s chapter is especially helpful for me as rehabilitation professional and a student who want to develop and do research on this issue. She helps me know where to start and what issues do we need more knowledge about. With contributions on international and multidisciplinary teams, her work is essential for all research on rehabilitation and minorities.

2.2 Cross cultural issues in goal setting: Locke and Lathem

Locke and Latham (2002), explores the impact of cultural values on individuals' perceptions of the meaning of goals, goal choices, goals commitment and the effect of different types of feedback on the goal-performance relationship. Culture is defined as the overarching shared meaning that represents similar patterns of perceptions, basic assumptions, values, thoughts, emotions, and behaviours in response to external stimuli. The shared values and norms are transmitted from one generation to the next through the social learning. It is also emphasized in this study from 2002, that the cultures with strong norms and lack of tolerance to deviations from norms are considered to be tight cultures. And loose cultures are more tolerant, of, deviations from norm. So individuals in tight cultures tend to conform to the norms more than individuals in loose cultures. There is an expectation of higher level of group goal commitment in tight cultures when the goal adheres to the cultural values than loose cultures, where individuals follow their personal rather their group goals. The authors

too describe the effect of the cultural values of collectivism versus individualism; power distance and uncertainty avoidance on goal setting and its performance outcomes has been examined in this article.

Locke & Lathem (2002) note that most of the western cultures, advocate individualistic values, which emphasize individual autonomy, self-fulfilment, uniqueness, and concern for oneself over others. And in contrast to most of the Far East and South Asian cultures the importance of collectivistic values, emphasizing social embeddedness, interdependence, and concern for the group over the self. Individuals strive to maintain a positive self-view, and to experience a sense of self-worth and well-being. Yet, the meaning of a positive self-view depends on cultural values and hence differs when serving the independent versus the interdependent self, or the relational versus the personal self or the collective self. Such differences in cultural values and in self-interpretation, the independent and the interdependent self explain differences in preferences for influence goals as opposed to adjustment goals. Influence goals denote asserting the self and changing others. It is further examined in the article that the role of independent goal pursuit for fun and enjoyment and interdependent goals pursuit to make friends and family happy.

In the article they describe how culture serves to answer the question of why people in collectivistic cultures may choose different goals than people in individualistic cultures, and why the same goal is sometime chosen, but for different reasons, by different cultures. The goal setting theory in this article, which has shown to activate action plan goals, has important implications for motivating global employees, who have to overcome cultural and geographical distances.

2.3 Self or group: Cultural effects of training on self-efficacy and performance: Early P. Christopher

Early (1994), focuses on self-efficacy and its relationship on training. More specifically, he compares the impact of individual versus group-focused training on self-efficacy, effort, and task performance in two intercultural studies conducted across the cultural dimension of individualism and collectivism. This has been important for my research questions.

Earley, (1994), has analysed that there are several typologies of cultural dimension such as individualism and collectivism culture. Both have a big role in shaping self-efficacy. He notes that in an individualistic culture, people intend to look to their own actions to understand who they are, and these actions are relatively independent of others. Workers strive to improve work performance because of the recognition he or she may receive. While in a collectivistic culture, people base their self-understanding on the reactions of others around them and workers from a collectivistic culture seeks improvement because of the gains his or her group may receive. Thus, people`s self-concepts are regulated, in part, by their cultural orientation and values and culture, people base their self-understanding on the reactions of others around them. It is rather suggested that individualists use privately referenced information for example their own performance in establishing their self-efficacy. While the collectivists use in-group referenced information for example the in-group´s performance, and that other aspects of culture being comparable, both individualists and collectivists sample the public self with equal frequency.

In the study the role of individualism and collectivism in shaping self-efficacy is explained. The theory of self-efficacy that is used in this study is inspired Bandura. Self-efficacy beliefs are the core-determinants of human behaviour according to Bandura‘s social cognitive theory. Bandura (1986) postulate that self-efficacy influences performance and an individual with high self-efficacy works harder and longer than an individual with low self-efficacy. Early further says that self-efficacy is socially constructed and that such construction may differ as a function of national culture. Just, as our culture teaches us what ideals to hold on to and what beliefs to endorse (Early 1994).

In the study different tests were carried that showed that efficacy training differentially shapes a person´s performance depending on the relationship of the training method to his or her individualism-collectivism orientation. It also showed that people who were high on collectivism-group and collectivism-individual (collectivists) responded best to group-focused training information, whereas people who were low in collectivism-group and collectivism-individual (individualists) responded best to individual-focused training.

Early (1994), concludes that the study clearly shows that organizational training that is culturally misdirected is also misguided. He further states that a collectivist´s self-efficacy is based on information that he or she gets about a work group. Whereas an individualist´s self-

efficacy comes from self referenced cues. The point is that to understand managing in an intercultural context requires a depth of understanding at both the cultural and individual.

As supplementary to Earlys´ study I focus more directly on different between collectivism and individualism culture when it comes to rehabilitation, reablement and goal setting in home care. There are few studies that focus on rehabilitation and cultural diversity, and as far as I have found in my search, there are no studies on adult´ minorities and reablement in home care (see my research question in section 1).

3.0 Theoretical perspectives.

This chapter deals with theories and concepts that are applied in my study. In the first section I explore on the concept of culture, explanation of individualism and collectivism culture, description of ethnocentrism and cultural relativism and the importance of cultural awareness. The relationship between health and culture is also outlined. The next section is about the different definition of rehabilitation and home cares reablement and the explanation of goal setting in both individualistic and collectivistic culture.

3.1 What is culture?

Culture is one of the most controversial concepts in the social sciences and has been explored by sociologists and anthropologists. There is no universal agreement on how to understand the notion culture. It can be defined in many ways by different people or with the different point of views, values and traditions (Magelssen, 2008). Anthropologist Edward B. Taylor offered a broad definition, stating that culture as a complex that includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society (Bennett 2015).

Based on this understanding, for example, we say that Muslims go to the mosque because they have a specific religion and it is often said that because people from Norway like skiing this can be part of their culture too. Sometimes it can be right or useful to describe a culture in this way, but this concept of culture can easily be misused. The impression that cultural divisions are deeper than they actually are can be overwhelming or sometimes devastating. For example, it may be tempting to blame "cultural differences" for everything that goes wrong in the relationship between Norwegians and minorities, although there are often other causes of conflict. Culture can be a mystifying term, which embodies as much as it explains - therefore we should treat it with caution (Eriksen and Sajjad, 2015).

The culture we live in characterizes our everyday life. Culture is something people have not only have learned but also has been transmitted largely from generation to generation. It has become a part of themselves because they have grown up in an environment that has taught them certain things about what the world looks like, right and wrong, and how to behave (Eriksen and Sajjad, 2015). When minorities migrate they normally take part of their culture

with them. You find things like gender, food, hygiene, communication, health, family relationships and many more is important to them. By migration, it is often important to confirm own values, norms and identity. It is important to eat what you are used to. There are nevertheless countless examples that Norwegian health professions do not take the starting point of the individual, but have a very ethnocentric way of guiding.

Food is a cultural term, and this is what we are going to explore. It is therefore interesting that the anthropologist and nutritionist Marianne Lien (1989) says that despite the fact that the connection between food and culture appears open, scientific studies of food culture have been few. Food thus has a communicative function. When preparing food for a person, the food expresses much more than the fact that one must eat to get the right nutrients. The food expresses, among other things, identity, cohabitation, friendship, love, humility, reverence, dissatisfaction, and distance. Different dishes can express different opinions (Eriksen and Sajjad, 2015).

For some ritual purity is part of their culture and religion. The purity of the body is, according to Islam, a fundamental condition for the purity of the soul. Muslim patients or clients must cleanse themselves before prayer and Quran reading. And after every toilet visit, Muslims do clean themselves with water (Hanssen 2007).

Gender also serves as a cultural meaning system. Haavind (2000) points out that gender is a meaningful content. That is, an organizing principle for how women and men understand each other and themselves, thus creating meaning for the reality they live in. What men and women do and how they interact with the ideas and interpretations of gender differences constitute a gender meaning system. For example in Muslim culture there is restriction when it comes to gender. There is no touching between men and women that are not related. It should ideally be male health workers who take care of male patients and female health workers who take care of female patients (Hanssen, 2007).

Culture has also several typologies of cultural dimensions such as individualism and collectivism (Earley 1994). In the individualistic culture such as Western societies people tend to look to their own actions to understand who they really are, and these actions are relatively independent of others (Earley, 1994, Wagnar and Moch, 1986). Trandis (2001) claims that individualism can be defined as a cultural state of affairs where people are

autonomous and independent from their in-groups. According to Kim (1994) individuals focus on, among other things, the sense of consciousness, autonomy, independence, the individual initiative, the right to privacy, the need for self-chosen friendship, regardless of family or clan, and universalism (Hanssen 2007, s68). Hanssen (2007) states that individualism can be defined as a social organization where individuals are only expected to take care of themselves and their immediate family. She furthers notes that according to Kim (1994), individualistic societies focus on "I" awareness, autonomy, independence and independence, the individual initiative, the right to privacy, the pursuit of enjoyment and entertainment, financial security, the need for self-chosen friendship regardless of family or clan, and universalism.

Adult minorities come from a collectivistic society, being part of a social group and larger networks are very important for all people. Hansen (2007) says according to Hofstede (1993), that collectivism stands for a social organization with close social ties between the individual and the extended family, the clan, whose members of the group are emotionally closely linked to and dependent on each other. The family or the group protects the individual as long as he/she exhibits blind loyalty to this and the relationship meets the expectations made by him or her. In a collectivistic view of life as in adults´ minorities´, the children are raised to appreciate their family and there is the togetherness within the family. The individual has a happy life if the family's life projects are realized and if the family as a whole is well-functioning (Skytte, 2001). Most of these adult´ minorities live with their extended families under the same roof. The collectivistic family structure often conflicts with the more individualized western way of thinking about a family. In collectively oriented families, more generations live under one roof where they are used to solving family problems in the family where the elderly have great authority and power. This picture is more complex in terms of collective life form among immigrants in Norway (Skytte, 2008). In collectivism culture the family of the clients are very much involved in the rehabilitation process, thus deciding the goals to be achieved here. The family has been viewed as an important factor in the rehabilitation process (Sander et al, 2002).
The diversity of individualistic culture and collectivistic cultures can be a dilemma for health professionals in Norway.

3.1.2 Ethnocentrism, cultural relativism and cultural awareness

The concept *ethnocentrism* originates from ancient Greek ethnos (people, peoples). You place your own people in the center and rank everyone else on a scale according to how much they resemble one. The ethnocentrician is unable to see other cultures (Eriksen and Sajjad 2015). According to Magelssen (2002), ethnocentrism is judging another culture solely by the values and standards of one's own culture. But, as far as possible, it is an advantage if we try to remove something from our own reality conception when we want to get in touch with people with a different cultural background (Magelssen 2002). Leavitt 1999b notes that ethnocentrism is the belief that one´s own culture is superior to others and is the standard by which all other people should be judged (as cited in Hammell, 2006, page 76). Ethnocentrism is often manifest in the assumption that the values, priorities and perspectives of one´s own culture are universal, rather than specific.

Cultural relativism can be rather a positive approach when it comes to adult´s minorities in rehabilitation. Culture relativist attitude, has the view that cultures are relative and can only be understood by themselves. According to an established culture of relativistic thinking, it would be impossible to rank cultures by quality, morality or development (Eriksen and Sajjad 2006). Magelssen (2002) suggests that cultural relativism is the idea that a person's beliefs, values, and practices should be understood based on that people´s own culture, rather than judged against the criteria of another. Ethnocentric is ultimately unable to communicate with the rest of the world. The cultural relativist, in turn, is out of the question to take moral position to anything. The most important insight from culture relativism is that all human beings must be understood in their own context. Neither a pure ethnocentric or a pure culture's relativistic attitude is possible or desirable in practice (Eriksen and Sajjad 2015).
It is important for health professionals to be aware when it comes to adult´s minorities' culture.

Cultural awareness is the self -examination and in-depth exploration of one's own cultural and professional background. This process involves the recognition of one's biases, prejudices, and assumptions about individuals who are different. Without being aware of the influence of one's own cultural or professional values, there is a risk that the health care provider may engage in cultural imposition. Cultural imposition is the tendency of an individual to impose their beliefs, values, and patterns of behaviour on another culture

(Leininger, 1978). Awareness of such issues is needed to promote more culturally competent. Bhui, et.al, (2008) note that health professionals need to be aware of possible cultural variations in order to provide culturally competent care, which invites cooperation with patients and their family members, and ensures the best possible outcome is obtained. In healthcare settings, cultural awareness, sensitivity, and competence behaviours are necessary because even such concepts as health, illness, suffering, and care mean different things to different people. Knowledge of culture enables healthcare professionals to provide better care and help avoid misunderstandings among staff, patients, and families. Hammell (2006) suggests, theories are more than sets of formalized ideas, taken for granted assumptions or system beliefs: how we think determines how we act. In order to achieve good cooperation with clients, there are several aspects that are at play such as trust and good communication.

Jensen & Ulleberg (2011) describes that all living creatures communicates and they ask if it is possible not to communicate. In such an understanding, the communication will be something we are in and that's something we cannot get out of. Communication can, therefore, be understood as a continuous changeable and complex process where we continuously send and receive information. The human being is, therefore, to be regarded as always in change and in mutual communication with others and with the world. Communication is about more than words and body language and, according to Bateson (1972), includes communication with the environment. Jensen and Ulleberg (2011) assume that Bateson's communication theory can be found in the border between the cybernetic and the socio-cultural tradition. Cybernetics was developed to describe and understand ecosystems and interactions in nature, as well as to create a new understanding of communication between people (Jensen & Ulleberg, 2011). In the communication theory tradition associated with Bateson, the socio-cultural, the language is seen as the link between culture and the individual's thinking. This tradition is concerned with describing, analyzing and understanding interaction patterns between people within a cultural and historical context. It is also emphasized that people, in contrast to the animals, communicate through symbols, and that through symbolic communication we can take the others' perspective (Jensen & Ulleberg, 2011). Martinsen (2002) draws on Skjervheim (1957) its description of the three-way relationship. A three-way relationship takes relationship based on the other person, the case and myself. Both will listen to what the other says about the matter and relate to this matter. In order for it to be a three-way relationship, it is necessary that the person being told about the matter respects the case and discusses it with the one who took it up. The

three-way relationship means that two people are talking about the third, the case. Martisen (2002), p.20) summarizes in his article Kierkegaard's well-known words about the "secret in all help art", *"Finding out mentally where human being is or being interceded in relation to the other is the secret of all help art".*

Many clients with minority backgrounds are exposed to this danger due to poor Norwegian skills. Language barriers or lack of language skills in a foreign country constitutes an additional risk factor like trust.

Skår refers to Frank et al. (2010), which describes that;

> *The basis for all health systems is meetings between people who have different needs for healthcare and people who, by virtue of their competence, are trusted to exercise healthcare. The trust that is exchanged is based on the composition of professional knowledge and service orientation governed by ethical commitment and socially responsibility* (Skår, 2013, p. 70)

There is no adequate definition of the concept of trust that is widely recognized by all. He describes an understanding of trust as a conscious choice where one weighs for or against whether a service provider is worthy to take over that which is of value. It's common to trust someone in certain situations without necessarily having to trust them in all situations. One can say that trust is normally conditional, limited and specific. By showing confidence in someone, you deal with few or no precautions. The counterpart can be called distrust, where you deal with precautions and caution. Mistrust is easy to create but hard to get rid of. Confidence is easy to tear down but difficult to build. By giving some confidence, you also open the action room for the trust recipient. There is broad agreement that the trader is acting on the basis of expected trustworthiness at the recipient. However, there is disagreement about what expectations are, how they are formed and how the development can be explained.

Grimen (2009) discusses the relationship and the asymmetry, the lack of equilibrium between two parties, which exists between the client and the health professional. He points out that the relationship between the professional and the clients is characterized by what he calls epistemic asymmetry. Here the health profession has knowledge and this knowledge is

something the client needs. Slettebø (2012,) describes that professionals need to be trusted by a client to ensure a prudent offer. Hammel (2006) states that the professionals' tasks are to be active contributors to enable the clients to master themselves. She describes this by the fact that professionals actively participate in their own experience and knowledge, while at the same time recognizing the client's own expertise and learning from them. There is an ethical obligation to take care of client autonomous decisions in trust and to motivate client in such a way that the rehabilitation / targeting process becomes an important part of the client's own will to restore dignity and lost functions.

3. 1.3 Health and Culture

Health is a concept that has been used in several ways. World Health Organization (1948) defined health as,

> *"A state of physical, mental and social well-being and not just absence of disease or weakness" (WHO, 1948, p. 100)* (translated by the author)

Austeveg (1994) notes that the definition has been widely discussed and there is a broad consensus that it is quite unmanageable in practice. As a human being, there is always creating, challenging destiny, and mastering a situation. World Health Organization health definition entails a standstill. It gives one that feeling of describing a life without risk and without the possibility of human growth. This definition makes all people sick and physical, mental and social well-being is in the same category. Western concepts of health appear to have been built into the world health organization definition of health in which acknowledgments of possible associations between spirituality, religion and health is lacking. This could have possibly led to a paucity of research in this area. Brodtkorb and Rugkåsa (2009) say that Austveg (1994) prefers to define health as a form of the viability of life. She defines as such:

> *Health can be defined as our ability to cope with our life situation, with a good balance of self-control over your own life situation, and having a network that we can trust and also be dependent on. Health has to do with the ability to withstand stresses and it also has opportunities and potentials to do. Most of us will emphasize the ability and ability to stand on our own (Brodtkorb and Rugkåsa 2009) (translated by the author).*

According to Antonovsky (1996), health could be understood as a contour on an axis of absolute disease and complete health. The *sense of coherence* is the ability to use or make own overall situation and own capacity by using available resources. This capacity is a combination of people's ability to gain an understanding of the situation they are in and to find an opinion in moving in a health promoting direction. In other words, having the capacity to do such actions (Antonovsky 1996). There is also the Bandura's (1997) model of self-efficacy suggests that the self-management approach can be a useful tool to help overcome the barrier to different health and recovery expectations and beliefs. Both definitions involve accepting what one cannot change and establishing more realistic expectations for health.

Brodtkorb and Rugkåsa (2009), claim that in the rich part of the world, health seems to represent a core symbol that has significance far beyond itself. Perhaps we can say that health is what life is about. This is linked to a strong ideology of the individual that leads to the individual's responsibility in terms of himself and society in order to maintain his or her own health. In the Norwegian culture, one can say that it is common to think about cause and effect of health or one is sick and working towards being healthy. Røkenes and Hanssen (2006) say that when something is the cause of something else, we are talking about the linear cause. In interpersonal relationships, this thinking is common in our culture and words as due to and because of this. It can be easy to understand events as something happens in a linear order, and that something happens first and is the cause of what happens afterwards.

Hammell (2015) writes that Kagawa-Singer (1993) claims that the definition of health articulated by people living with cancer that has considerable utility for rehabilitation. They defined health as:

> *"Based on their ability to maintain a sense of integrity as productive, able, and valued individuals within their social spheres, despite their physical condition" (as cited Hammell, 2015 pg.51)*

Culture plays also a central role in health-related behaviours (Carroll et al. 2007; Omu & Reynolds 2012). Different cultural groups have vastly different perceptions of the causes of disability or impairments, disease and these perceptions influence their health-seeking behaviour (Bailey et al. 2000). Maarouf (2015) also notes in his article that in Moroccan popular culture poor health can be seen as the evil eye. An evil force that tracks people's steps

either to other's ill will, envy or act of magic. And by attributing their failures, social problems and misfortunes to the evil eye, people feel they are no longer liable for their own doings, and place responsibility on the others. This is an example of societies that believe illness as a result of supernatural or other spiritual interventions that counter the presumed disfavour of powerful forces. Hammell (2006) notes that the moral or religion model of impairments is concerned with ascribing a cause for impairments. Perhaps trying to respond to a human need to explain why bad things happen and publicizing the belief that impairments is a result of sin, witchcraft, the evil eye, the wrath of God or ancestors' anger.

Religion is still an important element in much of the world, which means that one has to relate to religion in a certain way. Health and impairments can be described or practiced differently in different cultures. Religious beliefs and rituals form part of culture, and influence the ways in which people cope with adversity, such as illness and disability. Positive support may be derived when God and religious figures are seen as benevolent (Pargament, at el.2001).

Brodtkorb and Rugkåsa (2009), claim that health conceptions in western societies differ greatly from the concept of health, for example, the Middle East. Their people with the small economic elites can adapt this form of health constraint like in the rich part of the world. The majorities again have the opportunity to relate to such a refined understanding of risk. Of course, health is also important, but it does not seem to represent any goal in itself. Health is not something one is striving to achieve, it is rather something one sees as a logical result if one has sufficient financial resources, living in a good family and following God's rules. Health is not about getting in shape, but about getting in balance. It's not about better motion, but about calm. The main focus is not on individual responsibility, but on the collective responsibility to protect the individual from internal and external imbalances as one imagines will lead to loss of health. When a person's actions are rooted in the fact that she understands the other, the actions will again positively affect the relationship. If the person's actions contribute to the strengthening of the relationship, the parties may enter into a good circle of interaction. It can be described as a circular circle (Røkenes and Hanssen 2006).

All adult´ minorities want is to recover and be as they were before, while Health professional intention is to engage the client in more physical activities to be independent, but this can be unrealistic thought. Hammell (2015) believes that those that are more engaged in physical rehabilitation could usefully learn a new definition of recovery.

Hammell (2015) refers to (Anthony 1993; Rebeiro Gruhl 2005) who define recovery as;

> *"Recovery is defined in this context not as a cure but as a process of changing one´s attitudes, values, goals, and of living a hopeful, satisfying, meaningful, purposeful, contributing life within the limitations caused by one´s disease or impairment" (as cited in page, 57)*

Recovery for some may be to master a job or live a good life without medication, while for others it may be about moving on in life. Karlsson and Borg, (2013) claim that recovery is about retaking control, the right to have choice and influence and the right to have real cooperation with the health service. Recovery is a professional perspective that is based on the fact that recovery is a social and personal process, where the goal is that the individual can live a meaningful life despite the constraints the problem may cause (Directorate of Health, 2014). Maybe the adult´s minority will want to focus to recover than stress out with physical activities that are the fundamental focus for health professionals in rehabilitation.

Minorities belong to a collectivism and interdependence culture, where they depend on each other due to cultural norms. This is a culture that is not practised in the western world so, its important health professions to know how to relate to health in their culture.

3.2 Rehabilitation and home care reablement

Rehabilitation is a central component of health care delivery, as well as a vehicle for helping people to play an active role in managing their own health.
Rehabilitation has been defined in White Paper nr. 21 (1998-99) Responsibility and coping such:

> *"Time restricted, planned processes with clear objectives and means, which several players cooperate to provide necessary assistance to the user's own efforts to achieve the best possible function and coping skills, independently and participate socially and in the community" (Regulations on Habilitation and Rehabilitation, 2011, Chapter 2, § 3)* (Translated by the author).

The governmental definition clearly states that rehabilitation should involve collaboration, clients involvement, clear goals and value-added against the patient's daily lives. The actors

around the clients need to support and provide relevant and necessary assistance so that the patient through active participation can achieve the goals set. In order for this assistance not to be perceived as divided and random, it is therefore important for good coordination and interdisciplinary cooperation between patients, relatives and the different groups of subjects around the patient (Normann, Sandvin, & Thommesen, 2003). Rehabilitation is often associated with physical exercise to recover completely or partially lost functions.
In the definition of rehabilitation, it is a clear requirement that clear goals should be specified for the individual clients. In addition, under the remarks of the Regulations on Habilitation and Rehabilitation, has been commented that "special emphasis should be placed on the time allocated to the user's own goals" (Regulations on Habilitation and Rehabilitation, 2011, Note to § 5). Rehabilitation emphasizes of one being independent or self-reliance. This can be seen as an individualist approach and this definition has been criticized a lot and thus why the government is working on a new definition. The legislation thus places strong guiding principles on goals of being included as part of the rehabilitation process.

In contrast Hammell do not defines rehabilitation as treatment of body parts but as a process of enhancing well-being and of attaining or regaining a meaningful life in the context of illness, disease or impairments. She further suggests that rehabilitation could usefully be regarded as a process of enhancing engagement in living (Hammell 2015). Bury (1991) views the usefulness of adult who has impairments or is ill as a sign of life disruption. Not only a dysfunctional body but as a disruption of daily occupations, valued roles and future hopes (Hammell 2015).

Home care rehabilitation or reablement has elements of health promotion and work as a prevention disease. It is primarily a rehabilitative workplace. The National Board of Health and Welfare (2013a: 5) defines home care reablement as follows:

> *Home care reablement is the common term used by the municipalities in describing the rehabilitation offerings targeted at home care carried out in the citizen's home or local community in order to improve the functioning of the citizen and make them more self-reliant in everyday life.* (Tuntland and Ness, 2014 page, 25) (Translated by the author).

Tuntland and Ness (2014) note that the definition above is wide and unpredictable as it encompasses all forms of home rehabilitation, in fact, does not differ from traditional home rehabilitation at all. Førland and Skumsnes (2016) define reablement as:

> *A time-limited, intensive and goal-oriented rehabilitation in the home and the local community of older persons who have experienced functional decline, where therapists, nurses and other employees in the home care services in the municipality collaborate and assist the person in daily practice and adaptation of everyday occupations which matter to the individual* (Førland & Skumsnes, 2016. s. 5) (translated by the author).

The goal of home care reablement is to train clients will be able to achieve greater independence, participate in activities that are important to them and to master the challenges that their daily lives give (Tuntland & Ness, 2014). An important starting point is that participating in activities or resuming past interests is central to creating structure in the person's everyday life, and that it contributes to the experience of meaning and coping (Prochaska, DiClemente & Norcross, 1992). Home care reablement can be understood both as a form of rehabilitation and as an approach where the clients self control participation and mastering their everyday life.

3.2.1 Goal setting in Rehabilitation and Home Care Reablement

In the governmental definition of rehabilitation, there is a clear requirement that clear goals should be specified for the individual client. In addition, under the remarks of the Regulations on Habilitation and Rehabilitation, it has been commented that "special emphasis should be placed on the time allocated to the user's own goals" (Regulations on Habilitation and Rehabilitation, 2011, Note to § 5). The legislation thus places strong guiding principles on the goal of being included as part of the rehabilitation process.

Goal setting in rehabilitation can be understood as a process in which clients and professionals enter into dialogue to determine or negotiate goals for the individual patient's rehabilitation (Playford, Siegert, Levack, & Freeman, 2009).
The purpose of setting goals is to steer the actions in a certain direction, as well as to create motivation for effort over time (Reeve, 2009). Rehabilitation goals are seen as a tool for achieving client-focused treatment, by providing the client with opportunities for identifying

problems, prioritizing goals and evaluating goal achievement. It is also considered to increase clients' motivation for rehabilitation and to contribute to better utilization of treatment time (Sugavanam et al, 2013). Wade (2009) points out that rehabilitation aims at two aspects: First, a goal is an imaginary future, which usually involves a change from the current situation or condition. In addition, a goal refers to thoughtful actions that will take place in the rehabilitation. That is, a goal should be a potential result of various measures and not just a prediction of the future.

Wade (2009) describes the steps in a targeting process to first identify which goals are important and significant to the client, then to determine which changes are possible or realistic, what measures must be taken to achieve the goal and where likely goal achievement will be concerned. The main message in goal theory, based on Locke and Latham (2002), is that the goals should be specific and difficult to achieve to achieve the best possible yield. This theory says that specific goals have a greater impact on performance than vague goals like "doing your best" or "getting better". In addition, goals that are perceived as challenging to the individual will help to improve performance. Goals create attention and performance, maximize stamina and create problem-solving in relation to the goal set. According to this, there are several factors that affect the efficiency of the goal of the individual: the perception of the importance of the goal internally with the person or external, the difficulty of the task, the person's most-favoured-mindedness and the type of feedback given. Playford et al. (2009), however, believes that the theory has limited transfer value to the rehabilitation field because it is in conflict with clinicians in rehabilitation generally perceives as important, including the perception that the goals should be achievable, realistic and motivated by the clients. Reeve (2009) also insists that targeting theory is essentially about improving the performance of those involved and that it takes little account of the motivational aspect of the goal.

According to Bandura (1993), will individual's self-efficacy have an impact in goal-setting process, both in relation to the goals set, the amount of effort put down to achieve the goal and the extent to how much adversity will be tolerated. The degree of self-efficacy in the individual is largely based on previous experiences with similar challenges. Earlier experiences of mastering will increase the faith in the new mastering, while experience of failure will give the opposite effect. Situations or activities where expectation is higher than belief always is avoided by people (Bandura, 1993). Based on Bandura (1993), low self-

efficacy esteem will give little encouragement to act while strong self-efficacy esteem will make one aspire to set high goals and follow these up while making a robust effort to continue striving for goal achievement even if one fail or experience a decline. People in individualist cultures prefer to pursue goals that are directed at achieving personal success and seeking social independence.

Goal setting can differ when it comes to adult´s minorities due to collectivism culture. Locke & Latham, (2002) say that (Kurman, 2001) claims that challenging goals serves as a strong motivator for Westerners, and that is because they offer an opportunity to distinguish oneself from others. This is not the case in collectivism culture, where people define themselves in relational terms and as being as part of a collective. They prefer moderate goals that do not differentiate themselves from others and attenuate the risk of falling out of the group they represent. Culture values tend to explain or answer the question of why collectivistic cultures may choose different goals than people in individualistic cultures. Adult minorities' clients need different approaches in targeting their goals. Hammel (2006, p 77) refers to Batterham et al. (1996) when she writes that high expectations from a helper contribute to achievement. In reablement clients are trained at their homes, Debesay and Slettebø, (2012) note that even though help is carried out in client's homes and on his or her own premises, the biggest challenges are that routines and standards of professional practitioners often challenged (Solvang and Slettebo, 2012 page 132). Cooperation in a goal-setting process between health professions and clients is considered as a fundamental part of the rehabilitation process (Brewer, Pollock & Wright, 2014).

3.2.3 Summary

I have outlined theories that in my opinion help me to analyse my empirical data. I have chosen to outline themes of individualistic and collectivistic culture, culture and health, rehabilitation, goals achievements in rehabilitation and family involvements as interesting dilemmas to study. In addition, concepts as cultural awareness, ethnocentrism, cultural relativism, communication and trust are also included. These perspectives will help me to initiate an analysis of the empirical data and answer the research questions.

4.0 METHODS

4.1 Research methods: qualitative interviews of health professionals

In this chapter, I will explain the choice of research method, approach for analysing my data, challenges with conducting the interviews and research ethical reflections related to this project. I will also introduce my informants and give an insight of selection choice.

Malterud (2003) points out that the qualitative method is an appropriate method to use when one wants to know or learn more about human qualities, experiences, thoughts and expectations. In order to produce an empirical material, I, therefore, used qualitative research interviews as a tool for collecting data. Through a research interview, the researcher learns to know others, learns about their experiences, feelings, hopes and the world they live in (Kvale 1997, 72). Interviewees are in possession of knowledge and life experiences and I want the insight of it (Ringdal 2007).

The phenomenon I want to investigate is the challenges that health professionals face in rehabilitation with adult´ minorities in home care reablement and how these experiences can be understood. In order to produce an empirical material, I therefore use qualitative research method where I use interview of health professionals as a tool for collecting data. Through a research interview, the researcher learns to know others, learns about their experiences, feelings, hopes and the world they live in (Kvale 1997, p72). The informants are in possession of knowledge and life experiences that I want insight into (Ringdal 2007).

4.2 Interview as a method

I have chosen semi-structured interview to collect my data. Kvale (1997) defines the qualitative research interview as a professional conversation. Such an interview is to formulate questions that let interviewee describe their experiences in a freeway and in their own words. The reason for the choice of method used is based on the choice of themes and issues. The purpose of this project is to gain an understanding of what is the challenges that health professionals face in rehabilitation with adult´ minorities in reablement and how this experiences can be understood The intention is that the informants describe their own experiences in a freeway and in their own words, and how these experiences can be interpreted and understood by others (Tjora, 2012).

The research interview reveals information that is not objective but subjective. This information depends on the person being interviewed. Finstad (1997) believes that the qualitative research interview is particularly suitable when you want to get the subject's view of its world. It is a method that allows you to change directions along the way based on the information the informant brings. In this way, information may not be obtained using another method (Marshall & Rossman, 1999). All six interviews I conducted had an open form where I did not have to ask all questions in order. In certain cases, it was enough to ask a topic introducing questions and then follow up and deepen the informants' answers. It is important to follow informants based on their own expressions of what they consider important. This kind of openness keeps the possibilities open to other unexpected but perhaps important topics that the scientist has not thought in advance. Finstad points out that the qualitative interview can or should be standardized. "It is primarily the follow-up questions that distinguish an" oral questionnaire "from a qualitative interview. The follow-up questions will be theme, time, and personal"(Finstad, 1997: 59).

During the talks, I mostly emphasized on allowing the informants to lead the conversation, but with follow-up questions so that they became theme-related. The informants shared their experiences. As a researcher, it may at times be tempting to lead the informants' answers in directions that support the researcher's perceived as a possible statement or interpretation in one way or another. An example may be that the informant gets the feeling that "most people have said" or "many of the others think". I was, therefore, a little afraid of being one-sided and for their statements to be overshadowed by my attitudes so that they would be pushed into the appropriate theories that I had in my mind. My informants were probably not unaffected by my role as a researcher, but I do not think this influenced the interviews to any significant extent.

Kvale (1997) writes that thorough preparation is important for a good result and that a great deal of the survey should take place before admission to the actual interview situation. As I had embarked on the project's theme, it was not difficult for me to understand and follow up the informants' expressions. Before completing all the interviews, I had a conversation with my informants about the project's theme and purpose. I did not experience skepticism or uncertainty related to my project and I assume that the reason for this is that all my informants were well informed about the project both in writing and orally before interviewing (Kvale, 2007).

4.3 Selection and Presentation of informants

Selection criteria for informants were health workers that have experience working with adults' minorities in reablement. Seven informants were recruited through acquaintances that were health workers from different reablement. Three of the informants were ethnic Norwegian and four were from ethnic minorities all working in home care reablement in the municipality of Oslo. Unfortunately one of the informants that were a nurse with minority background decided to withdraw. I then decided to have the six informants that were willing to participate. My intention was to have two nurses that participated in the interview but only one could participate. I have changed my informants name to anonymize them. The table below illustrates my selection:

Table 1: A presentation of the six informants, after gender, age. Professional and county

Name	**Gender**	**Age**	**Profession**	**Land**
Tanya	Female	29	Physiotherapist (PT)	Norway
Pernile	Female	26	Occupational therapist (OT)	Norway
Amina	Female	32	Nurse (N)	Somalia
Borsilav	Male	29	Occupational therapist (OT)	Bosnia
Mari	Female	56	Physiotherapist (PT)	Norway
Mudagazi	Female	57	Occupational therapist (OT)	Zimbabwe

4.4 Completion and transcription of the interviews

The qualitative interview can be conducted in different ways. In the book *Systematics and Experience* (1998), Tove Thaagard gives three examples of this. The most common procedure that is being used in the qualitative interview is the partially structured interview. The researcher has decided which topics to talk about, but the order can be determined along the way. The researcher can follow the informant's narrative, and in addition make sure that the topics that were determined in the first place are highlighted. The researcher may also choose to follow a relatively structured structure where the most closely followed questions are prepared and the aim is to follow the planned order. In situations where comparison between the informants is important this is advantageous as this approach provides the best basis for comparable answers (Thaagard, 1998). Attached is my interview guide which shows that I have chosen to base my interview on a partially structured interview where it was decided in advance which topics should be highlighted while the order of questions was determined while interviewing. One last way Thaagard (1998) mentions is to follow a little structured scheme. This way is more considered a conversation between informant and researcher. In this way, the informant may feel less formal and rigid. It can be an advantage when it comes to openness.

The surroundings around the interview are worth reflection. Repstad (1993) claims that location selection may have an impact on whether the interview is successful. A good starting point is that the informant himself chooses the place. Often the informant will choose his or her home or workplace. Ryen (2002) emphasizes the advantage of conducting the interviews where the informant performs his natural activities, such as at home, workplace or even on the street. It creates security (Repstad, 1993). In relation to my informants, they choose a place they felt comfortable, they all choose their working place and after they were finished with their work.

Informed consent means that the interviewees are informed of the overall objectives of the survey, on the main features of the project plan and on possible advantages and disadvantages of participating in the research project (Kvale, 2007: 67). I prepared an information letter before I interviewed and sent written information to informants who had previously received oral information about the project's purpose. Those who participate in an interview are entitled to self-determination and autonomy, I informed everyone informants about voluntary

consent to participation and that they can withdraw from participation at any time if they feel discomfort or negative consequences, injury or risk. I also emphasized that all information will be treated confidentially and presented in a manner that allows the respondent not to be identified (Kvale, 2007).

I have used interview guide in my interview with informants. A good interview guide will make analysis work most transferable, valid and relevant to the focus of this study, and intuition about what the study wants to highlight so that the study theme constantly is in focus (Malterud, 2003). My intention with many conversations is thus to give me a deeper understanding of the challenges that health professionals face in rehabilitation with Adults' minorities in reablement and how this experiences can be understood.

To transcribe means to change from one form to another, or rather to transform. In this context, the translation of spoken language will be transformed into the written language (Kvale and Brinkmann, 2015). The conversations were recorded on audiotapes. It was chosen to get the informants' own formulations while keeping their attention focused on them and the conversation. The tape recorder was also a signal that this conversation is important since it was taken care of. Of course, I was aware of the norms and rules in the field of volunteering and anonymization, and that is why I did not experience scepticism associated with the project or audio tape recorder.

4.5 Analyses of the six interviews

I used the systematic text condensation that consists of four steps to analyse the raw data. When using systematic text condensation, essential knowledge and experience from informant perspective was analysed and to produce a new knowledge. I proceeded as follows:

Step 1: To get a complete impression, I started reading the data several times. Malterud (2011) says that the entire data is more important than eye-catching details. I tried to make myself as open as possible for the impression the material conveyed. Eventually, I summed up my impressions and set up preliminary themes that could illuminate my research problem.

Step 2: I conducted a systematic review of the data line by line, to identify meaningful devices (coding). Malterud (2011) does not recommend sharing the entire text but selecting text that somehow brings knowledge of the topics from the first step. For a good overview, I preferred to carry out the coding physically and materially. I, therefore, purchased 3 sheets in poster size. Each of these was labelled with each of the preliminary themes. I went so systematically through the printing of all the data and marked each meaningful device that I thought was related to the different themes. According to Malterud (2011), we will use themes as a guide to find the pieces of text that, according to their content, have something in common. These common text bits are then labelled with the same code (tag). To this mark, I used different colour pencils, so it would be easy to distribute the devices (text bits) under each theme. All of the branded devices were so physically cut out and placed in the bottom of the poster under the theme they belonged to. I also discovered that it was natural to code any of the same devices under two or more codes. The five themes I found were challenges between culture, expectation of recovery, problematic in goal setting and cultural awareness

Step 3: I now had five themes with each and every pile of encoded meaning-bearing devices. The way forward was now condensing the content of each of these five groups so that it would make sense. With systematic text condensation one works with the individual code group as a unit. Within each code group, I then sorted the material into several subgroups (Malterud 2011). According to a code group, if the material is rich and relevant, will cover several different shades that describe different meaningful aspects. Under each theme on each of the posters, the "names" of the corresponding subgroups were applied. I then took a code group at a time, sorted the meaningful devices and placed them in the subgroup they "fit in." To have a good system, I used colour pencils again. All the time I had discussions with myself about which devices were important to bring in. I was not only after something that was interesting but also relevant to this study. When the sorting was completed, the devices were glued to the poster, under the respective subgroups and code groups. I now had very clear "plans" of my preliminary analysis work. When the sorting was completed, the devices were glued to the poster, under the respective subgroups and code groups. The text above each subgroup appeared now as a condensate. According to Malterud (2011), a condensate will summarize and recount the content within the current subgroup.

In the last analysis step four (rekontekstuaslization), I tried to summarize and reassemble all the knowledge from each code group and subgroup. I based on the condensed texts and some

selected quotes and then made an analytical text for each code group. According to Malterud (2011), the analytical text represents the results of our research project

Table 2: My theme (code group) and subgroup is presented below.

Code groups (theme)	**Subgroups**
Challenges between culture	Gender, Hygiene, Food
Interdependence and not independence	Family always, Not raising a finger, family expectation
Expectation on recovery	To recovery fully, To recover as before, Fix things, If Gods willing.
Problematic in goal setting	Goals does not exist, They do not have desire, dividing goals in small section.
Cultural awareness	Have an open eye, put yourself in their situation, knowing who they are.

4.6 Validity, Transferability and Reliability

Validity means validity and how accurate it measures what it intends to measure and whether the results of the survey represent the reality studied (Thagaard, 1998). Validity turns out to be related to the interpretation of data. In qualitative research, it is common to distinguish between internal and external validity. Internal validity relates to how causal relationships are supported within a particular study. While external validity is often referred to as the transferability of the study and relates to how the findings and interpretations of the study can also be valid in other contexts (Thagaard, 1998). With the help of the informants I have related to what I intended to find out about. The Interview Guide ensured that the questions that were asked and the themes were the same in all the interviews. I have largely tried to be loyal to the informants' stories and render them the way they were told. If something was unclear, follow-up questions were asked to make sure I understood the informant correctly, and that at the end of each interview a summary was made where the informant had the

opportunity to correct the researcher. Interview, as method proved to be suitable for obtaining the health professionals thoughts and experiences with that was investigated. Furthermore, semi-structured approach was beneficial in terms of great flexibility, which provided room for informants to promote their experiences and views in depth. Nevertheless, it is not necessarily certain that what has been said reflects actual practice in workplace, since interviews as a method only provide indirect description of how the targeting process is taking place, according to Malterud (2011). In retrospect, questions may be asked whether the interviews should contain questions that focused on what happened after the day-to-day rehabilitation and whether the accomplished function was maintained or if there were other instances that came into play. This had given a broader understanding of the informants' experiences at home care reablement. Along the way throughout the research process, there has been focus on the study theme and research questions to ensure that the focus has been in line with the purpose of the study.

Transferability says something about whether the findings can be made applicable in other contexts than where the study was conducted (Malterud, 2011). Although few interviews were conducted, these interviews provided an insight into different experiences and challenges health professions had which targeted and evaluated adults´ minorities´ at home care reablement. These experiences may be recognizable to others who work in the same field of rehabilitation. It may therefore be thought that the results may have some transferability beyond this study, but it may also be that other health professionals who work with rehabilitation have completely different strategies in relation to adults´ minorities in home care reablement. However, as a researcher, I have attempted to create a distance to empiric by illuminating the material from different perspectives through a theoretical frame of reference in the interpretation and discussion of the findings. This can be helped to elevate the analysis in such a way that the study can say something about general relationships about targeting and evaluation work in rehabilitation.

Reliability can be linked to the question of whether a critical assessment of the study gives the impression that the research has been conducted in a reliable and trustworthy manner. It is largely about the researcher and if the researcher himself or herself say something about whether another researcher is using the same methods and would achieve the same result (Thagaard, 1998). Reliability is also about minimizing errors and quality assurance data. In this study, the purpose is to investigate the informants' challenges and experiences with home

care reablement. In order to safeguard relativity, the researcher has to be open and accounted for all stages of the research process and that understanding has to be described. I have also worked on my study so that it is possible to trace what has been written and constantly relate to the data collected in the interviews. By describing the research process step by step, the process is made "transparent" which further enhances relativity.

4.7 Ethical considerations

Prior to commencement of the study, approval was obtained from NSD (Personnel Ombud for Research). The consent of the informants was obtained in writing prior to the interviews and was provided on an informed basis. It was stated that it was voluntary to participate in the study and that it was possible to withdraw from the study at any time until data were included in the analysis. Efforts were made to safeguard the informants in the best possible way during the conduct of the interviews, including through briefing in advance and subsequent debriefing. Since I, as a researcher and my perspective, define the theme in the analysis it may lead to the alienation of the informant according to Thagaard (2009). In order to safeguard the privacy and maintain the privacy of the informants, the written material is anonymized and no traits that can be traced directly back to individuals are reproduced. The audio files and the written material have been stored in accordance with the NSD guidelines. The audio files will be deleted when the master task is completed.

Another important research ethnic side of interview as a method was to be aware of my position as a researcher in the interview situation. An interview is characterized by how researchers and informants experience each other in the interview process. External characteristics such as gender, age, and social background have an influence on how the interviewer appears to the informant (Thaagard 2003). I had been confronted with challenges both in the interview itself and in connection with my data processing and analysis. As I myself have ethnic minority background and a health professional, it would be right to say that I would probably see my informants in a different way because of my culture, and that my interpretation will be influenced by my experiences from work. I had to a lot of questions all the time like, how would I respond to this? Would I come to experience myself both as a researcher and as a minority? In retrospect, I have realized that reflections on my ethnic background have had positive impact on the interview situation as it helped me develop an

open relationship based on trust. (Thaagard, 2003) believes that the trust and credibility achieved during the interview provide the basis for informants to talk openly and share their life experiences. I think my ethnic background identity and as health profession became most visible to my informants. I reflected on this the similarity between my informants and me and in what way this may have consequences for the material I receive from them. In many cases, I found that my informants said, "Yes you know how it is". In such cases, I used interpretative questions to control my understanding and clarify that they had to explain to me what they meant. I felt that many of them took for granted that I could understand their expressions on the basis of my ethnic background and as a health profession myself. According to Kvale (1997), the material is analyzed and interpreted based on the understanding of the researcher`s framework. This means that the informants are perceived by situation is not in accordance with what I perceive as a researcher. This is something that I checked by asking interpretative questions to obtain as precise interpretation as possible.

5.0 Results of my analysis and discussion.

In this chapter I will present the results of my analysis and discussion will follow under each theme. The focus of discussion as mentioned in introduction, is the challenges health professions face in rehabilitation with adults´ minorities in home care reablement and how this experience can be understood.

The result of my material is presented under the following five main themes and subgroups. The middle is the topic of my studies:

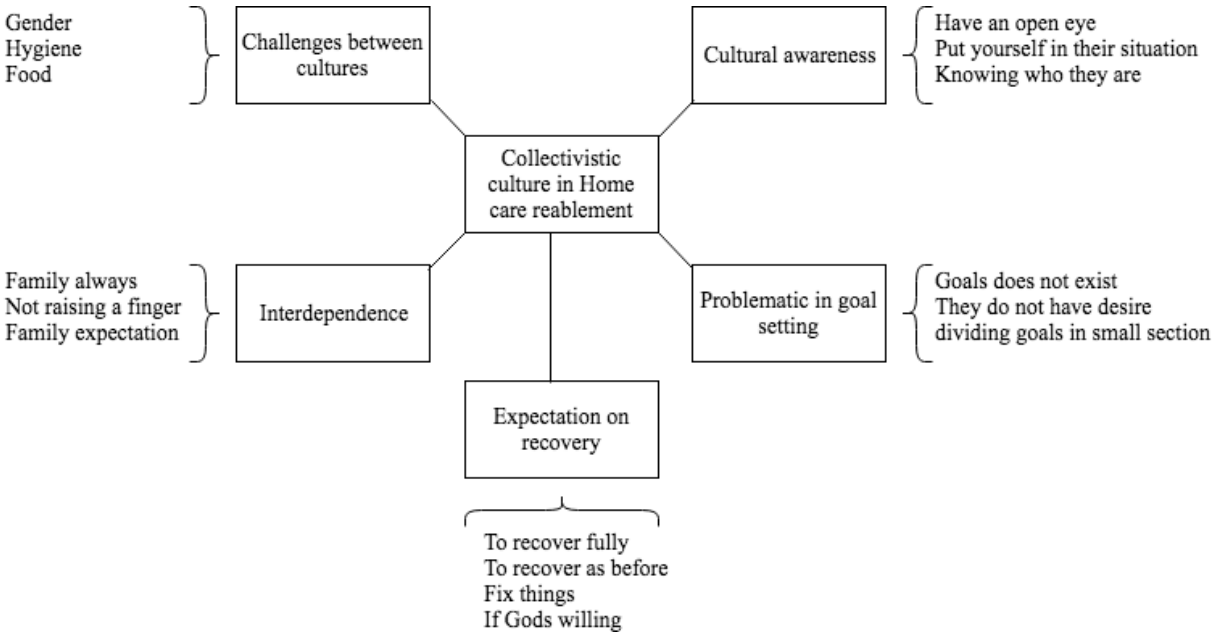

Fig. 1: It also shows correlation between subcategories, main categories with my main topic.

5.1 Challenges between cultures

As mentioned in the theory section where I refer to Earley (1994), culture has two typologies of cultural dimensions such as individualism and collectivism. Individualistic culture is more of self-reliance and collectivistic culture; people base their self- understanding on the reactions of others around them. There is obviously diversity in gender, hygiene and food.

There is obviously a big difference in individualistic and collectivist culture. Here I refer to Bennett (2015) to Anthropologist Edward B. Taylor definition of culture as a complex that

includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society. Culture itself is difficult to define and in practice it is even harder to understand. Clients coming from collectivist culture and into an individualistic culture as in Norway can be stressful and frustrating. The informants say that they actually strive to work with adults' minorities towards achieving the best outcome. Professionals are used to articulating what they perceived to be individual beliefs that promote self-independence. This frustration can be on both sides.

There are issues that appeared to pose somewhat of a dilemma for health professionals, such as gender. Most of the informants meant that gender issue was more of a cultural issue.

Borislav from Bosnia said:

> *Gender has been a problem if there has been a female client that I had to help so I had to go back to the office and see if a female therapeutic could meet the client. This is part of cultural dilemma that one relies on opposite gender in different ways.*

And every time Borislav the occupational therapist thought of how he could deal with this issue because he meant that his values are equal to other health professional and that all people are equal, even though gender issue is part of his culture.

Amina from Somalia states the same too:

> *Yes, we had a woman from Pakistani, whom we provided services to her expectation. For example, she wanted female nurses. We have managed so far to meet her expectation. This has got to do with her culture*.

The informant further meant that the dilemma here is when they refuse to get help from male health professionals, this was mostly observed among women clients. And if there are no female nurses at work that day there will be no activities. One of the female clients did not allow male therapeutic to touch her since it was forbidden in her religion and culture.

Two of the health professions experienced diversity in culture when it came to hygiene. Tanya from Norway says:

It is important providing help in according to cultural principle. We had a client that had a situation when she had to go to the toilet and wash after every visit to the toilet. I think this had to do with her culture or religion or was it because of hygiene. Then we gave the client access to wash her self with the new toilet has that facility.

Pernille who is a Norwegian OT explains:

I had a client who used sandals inside her home. I thought that was not hygienic to use sandals inside the house. One must be able to distinguish between prejudiced thoughts and those that are actually their culture.

Cultural diversity can be experienced in absolutely everything and anything. Mudagazi from Zimbabwe says that she experienced that one of the minorities' clients cultural food was very important to him to some extent that it affected his physical activities. Mudagazi emphases that food is culture too. She explains that:

There was a man client with a stroke and was from Africa. Luckily for him, he was right handed and so he still could use his right hand, the stroke had affected his left side. When we came to him, he never used to do much. He just sat there and looked depressed, and was not participating in any activities. Other health professionals concluded that he was just lazy and didn´t want to participate. I remember one time I visited him at home to assess him, to find out what an occupational therapist would help him. I found out that his priorities were that he wanted to be able to make his traditional food, which was gari (cassava flour). He said that he missed his traditional food. As an African myself, I understood his situation. He needed a stove guard, a guard to be put on his stove so that he could manage to cook gari (cassava flour) with one hand and the pot can still stay in one place. I remember that l had to go to my bosses in the community where I was working. I got the permission and got the man a gadget that was fitted on the stove so that the pot could stay at one place. I had to do several sessions with him to make sure he was safe and until when he made his gari independently and was so happy.

Health professionals met challenges in cultural diversity such as gender, hygiene and food.

Cultural diversity can be challenging in rehabilitation for health professionals and can influence clients' rehabilitation. Most minorities have a self-conscious relationship with their culture and try to define, describe and preserve it. One can ask the question of where does culture end for the next to begin?

The informants were challenged with issues as gender, hygiene, food and the fact that clients were more of interdependence than independence in their rehabilitation process. It can be terrifying to deal with other people if one does not know what to expect. The informants felt often fear surrounded by different cultures and wondered what manners were acceptable. They had all sought of thoughts going through their mind everyday as they were at the clients' homes to rehabilitate them. The informants experienced that culture somewhat affected the rehabilitation of adult´ minorities. It was difficult to distinguish between prejudiced thoughts and those that were actually their culture. However, at the same time this does not mean that one has to underestimate the importance of culture and cultural differences in meeting adult´ minorities. It is common to think that culture is something people have, which has become a part of themselves because they have grown up in an environment that has taught them certain things about what looks like right and wrong and how they are going to behave. Thus, it is also problematic to set limits for cultures (Eriksen and Sajjad, 2015). Mudagazi the occupational therapist explained her experience with one client that had to have his traditional food in order to engage him to physical training. In this case the client became independent by preserving his culture, but informants meant that it does not always end positively.

This leads us to what other scholars have said about my findings. In my study the health professionals interviewed expressed certain perceived cultural differences in home care reablement, which has been challenging. As mentioned before that culture is not only learned, it is also transmitted largely from generation to generation. Many of the skills, rules and knowledge each of us use daily, we have learned from the previous generation Culture learned from childhood can be very difficult to change. On the other side Jensen & Ulleberg, (2011), suggests that we should stop thinking that we meet another culture and start thinking that this is a meeting with another person, from another culture. We basically do not know anything about that person in advance. You meet a human being and not a culture. It is the knowledge that arises in our meeting that will form the basis for our contact and not all my general cultural knowledge. But at the same time in collectivistic societies, the

mainstreaming of collectivist or traditional life-orientation largely influences them by orienting them towards their consciousness, experiencing collective identity, emotional dependence, group solidarity, clan and family affiliation (Locke & Latham, 2002). Informants have experienced that collectivistic societies; emphasize loyalty to their groups while the group in turn cares for their well-being.

5.2 Interdependence and not independence

The Adult minorities do not interpret independence in the same way as the ethnic Norwegians clients. One of the informants meant that the issue of independence is there but is different in a way that we are used to here. But the rest of informants have experienced that Adults´ minorities are more of passive than ethnic Norwegian clients because their families are always there.

Amina the Somalian nurse said:

> *There is a big difference when it comes to minority and Norwegians clients. Norwegians clients are used to living alone and being self-sufficient than minorities. For minorities family is there for them always. It is very difficult for minorities to be independent.*

Two of the informants experienced some of their clients were not active in their everyday lives. They didn´t even want to not raising a finger Amina says that:

> *Mostly they think that we are there to do everything for them and not raise a finger at all.*

Tanya the Norwegian physiotherapist explains:

> *I have also met a client who lived with his family and could not even pick up his plate from the table after eating, even if he could functionally do it. But, this was a man then. So, I found out that the man is the head of the family and he is not supposed to*

do housework. So, in this case, it was not just goal oriented and self-governing in the rehabilitation.

Tanya who is a physiotherapist further explains that she has also experienced that adult´ minorities were more of passive and even expected massage as part of their rehabilitation. This was difficult for the informant to understand this culture and was a challenge to motivate them.

The family is also seen as a central influence on adult minorities. However, the role of the family in home care reablement was described as complex, both seen as acting as facilitators to the process but mostly also as potential inhibitors. Part of the complexity was deemed to be due to challenges of expectations between the adults' minorities, their family and the professionals. With adult´ minorities there is a lot of family involvement.
Two informants described there positive thoughts involving family members rehabilitation process would be necessary. Tanya from Norway says:

When you involve the family in they intend to control the client process. Yes, they certainly can. But, in my perspective, I think why change it? Why influence something that will turn to the direction where they can become more individualized? (…) I do not see the purpose of limiting families from rehabilitation process. I think they have a very important place in rehabilitation.

Mudagazi the OT from Zimbabwe says to that:

Ethnic Minorities are used to having like family around, helping and encourage them. So you find more of this support and like a therapist, it's easier to work with (..) I think the clients; their families and everybody else should be included especially in ethnic minorities if there are people like that around in order to help the person in rehabilitation.

Despite these positive experiences, some informants noted that family involvement was not always beneficial in promoting rehabilitation process. The most commonly cited concern was the families desire to look after the clients. There was a clash of expectation between the family and health professionals. The families of the ethnic minorities always want to do too

much and thereby limit the potential of clients achieving their goals. As Pernille the Norwegian physiotherapist describes,

> *I remember a family where there was a little older lady who had a stroke. She had opinionated family members. There were very many expectations such as wanting us to changing bed sheets every day. We came and did different tasks that were not really what we came here for, to begin with. They somehow had orders for what we should do for their mother. There were a lot of conflicts; they were not satisfied because we did not do what they wanted. At the same time, we did not meet the client with what was important to them. Even we were unable to engage the clients in their rehabilitation.*

Amina the nurse from Somalia explains too that the minorities' clients have families who want to protect them. She says that it takes health professions a long time to get to know the client. There always complication at first and sometimes after some meeting with them it ends well, but not always.

The families being around them all the time make the clients more interdependent. The informants have experienced the family being of the clients always have a lot of expectation from the health professions. But for some it has been positive to involve the families in this rehabilitation process. There are other scholars that have said about this issue that I discuss beneath.

Family involvement was seen for some of the informants as both as an inhibitory and facilitator. The Norwegian core family consists of mother, father and two children. And the ethnic minority's family consists of mother, father of the son and their wives and children. There are many who live with their extended family. The family structure of the large family is hierarchical, where age and gender are crucial for one's place (Eriksen and Sajjad, 2015). As the informants explained that family was always there with the clients. In rehabilitation process, family involvement can be important for adult´s minorities there was some indication that the inclusion of the family could positively enhance the clients motivation in his or hers rehabilitation. One informant felt that involvement of family could lead or turn clients to the direction where they can become more individualized. But on the other hand it can be challenging for health professions to deal with the entire family, while the focus

should be on the client. Some families as described by the informants were very demanding. There is a difference between Norwegian families and ethnic minorities families on how they engage themselves in the client's rehabilitation. For most people family and close relatives always get involved in clients rehabilitation in home care reablement. Family involvement is an absolutely necessary resource and a prerequisite for a successful rehabilitation process (Tuntland and Ness, 2014). Overall, all of the informants felt that the minority clients had a stronger attachment to their family than the Norwegian clients. This attachment the adults 'minorities had with their families was seen as cause for interdependence when it came to rehabilitation. Most of individualistic values are advocated in Western countries that emphasize individual autonomy, self-fulfilment, uniqueness, and concern for oneself over others. On the other side collectivism culture emphasizes the importance of collectivistic values, emphasizing social embeddedness, interdependence, and concern for the group over the self (Locke & Latham, 2002). The idea of the clients leaving in collectivistic values such families taking care of them and doing absolutely everything limited their ability to be self-independent and choose to be more passive. But this is an obligation that is expected from the families' members to do. Traditionally, the children have a special obligation to take care of their old parents by having them at home and let the family take care of them (Moen, 2002). And it is also their culture for men not to do anything, as one of the informants explains. She said she found out that the man is the head of family and he is not supposed to do housework. When men begin to participate more in the home, women are traditionally impaired. In the eyes of others they become weak (Eriksen and Sajjad, 2015).

Early (1994) describes that in collectivistic culture, people base their self-understanding on the reactions of others around them. Health professions found this to be challenging and difficult to implement self-efficacy strategy in home care reablement for adults´ minorities due to family involvement. According to Bandura's social cognitive theory, Self-efficacy beliefs are the core determinants of human behaviour. Individuals are not powerlessly controlled by their environments, nor do individuals control everything by their own free will. Instead, human functioning is viewed as a result of interactions among behavioral, personal and environmental factors. He suggests that these factors interact with one another in a bidirectional fashion such that an individual's behavior is influenced by his/her environment and internal factors, and an individual's internal factors are mediated by his/her behavior and environment, and so on (Earley, 1994). Bandura (1986) postulate that without

self-efficacy people are unlikely to produce outcomes they desire. Self-efficacy can be a valuable theoretical concept in the context of rehabilitation for adult minorities.
A perception of extended family involvement was also described as positive too. Extended families were perceived as being a source of support, encouragement and motivation. The disadvantages primarily related to over-helping the patient hence increasing their dependency, although some health professions also mentioned that they had experienced a lack of respect from families when they were at the clients' homes.

5.3 Expectation on recovery

In the recovery pathway, almost all informants in my study had experienced that clients frequently held the concepts of a "recover fully" or "recover as before" to their impairments, which ideally should be delivered by the professionals. Such a view was seen as a challenge for the health professional in Home care reablement. Tanya says that:

> *They have an expectation to recover and be as before, which can be unrealistic.*

Pernille from Norway says too that:

> *My experience depends on where the individual is from and what expectations they have for healthcare. Mostly they expect to recover fully.*

While Amina from somalia explains that:

> *They have high expectations. Well, they expect to recover hundred percent.*

Mari from Norway explains that the expectation in recovery process and attitude to illness by adults´ minorities´ was because the clients had a different view of being sick and healthy. They had an expectation of things being fixed. She says:

> *They have a certain expectation that someone will fix things.*

The treatment requires a long-term commitment, predominantly driven by the clients. Physical training was not part of what was in the clients mind. Mari says that it normally

takes a long time for the clients to get involved and contribute in what they actually are responsible for when it comes to their own recovery. Yet you are seen as an important contribution for things to happen. She doesn't know if one can blame only on the culture or if it´s human factor or that they actually want to leave it to others to do something about this because it´s much easier.

Amina explains that some of the minorities' clients can have different expectation of recovery or health due to lack of knowledge. She says:

> *I met a lady from Somalia. She had hip fracture, and it was a big disappointment for her that she could not bend her herself. In addition, she had urine infection. She didn´t understand all this restriction and all she wanted was to get well. As a Somali myself, I know that most of the Somali women have not been in school and have no knowledge about health and rehabilitation in general. Such lack of knowledge plays a very important role and it can be challenging.*

Mari perceived that underlying health or treatment beliefs and recovery were frequently challenging, yet lay the heart of promoting successful rehabilitation. Mari, for example, explained her perception that the understanding of their impairment itself was a considerable barrier to engagement with self-independent. An approach to life that included fatalistic beliefs and the concept that "God's will" dictates the outcome of an adverse health event with an ethnic minority.

> *We had a client from Afghanistan who was a very highly rated person from where he came from. He was a professor but was unable to relate to the fact that he actually had a body that he had to use. It was a bit so insignificant because in his mind he lived both here and there in Afghanistan. All he would say was "Insha- Allah" (if God is willing) whenever given tasks and that´s hard. Because in Norway, perhaps our everyday lives are not so closely intertwined with religion and for some minorities' it´s part of their lives. Then how are we going to do our work or give them the help they deserve? It is a dilemma.*

The issues noted above appeared to pose somewhat of a dilemma for the healthcare professionals. It was impossible able to articulate what was perceived to be individual beliefs and it seemed to affect the engagement of the clients' participation.
The idea of how they relate to health is like there is a third dimension they have to relate to, there is God, the client, and the good health. God has overall control but kind of their path is in Gods' hand and you can´t change the situation. It is the opposite of Norwegian way of thinking. Mari describes.

> *In Norway, we have a culture where one is ill and that one is working towards getting well, and you do not have a health gap in between. So if you do not get well, you are lost in a way. You can make an effort because you expect to be as before.*

For Mari the physiotherapist, some illness one can get better, but with some diseases, nothing can be done. For example, after a stroke, one cannot necessarily be as before. If you do not know that, then you have a big challenge. I have a goal and a mindset and the minorities´ think in a different way.
Having this circular way of thinking and attitudes towards health by wishing and believing that these would result to an effective change in their condition can be difficult. Because the health professions work from a western point of view and the minorities have a different point of view. But the scholars might have a different point of view on expectation on recovery, which I intend to discuss below.

The health professions have explained how the clients expect to recover fully and be like before. Almost all informants experienced that the clients wanted a holistic recovery in their rehabilitation process. The statements testify that the informants have spotted challenges of views regarding clients urge to recover, an expectation of fully recovery and being as before. For the informants this was seen as an unrealistic goal to achieve without the clients engaging themselves physically in their training. But Hammell (2015) suggest that following serious injury or illness and returning to a meaningful and satisfying life is of greater concern than the achievement of physical abilities. At the same time differences in view of what health is, I think may be a source of misunderstanding between what the adults' minorities want and what health professions expect from them. The expressions for expectation of recovery can be parallel to how health is understood in Norway. As one informant mentioned that in Norway one becomes ill and works hard to become healthy and there is no gap in between

that thought. That is a linear way of thinking as explained in theory section. Thus when something is the cause of something else Røknes and Hanssen (2006).
In the next paragraph, the discussion goes on summarizing the informants' experiences and challenges of expectation of recovery with Adults´ minorities, as described in the literature as an important factor.

The informants suggested that the differences in recovery concepts based on cultural and religious beliefs understandings did not only influence the clients rehabilitation but was also challenging. And the role of the professional as the expert has particularly potency in adults´ minority client and the understandings or attitude such as the desire for someone to " fix things" deemed to influence the success of their recovery. One of the informants said that the clients saw her as an important contribution for things to happen. The informants explained that it was of no importance to the clients to train and be physical independent, even if it were the only solution. On the other hand Hammell (2015) claims that returning to a meaningful and satisfying life after an injury or illness is of a greater concern than the achievement of physical abilities. She also claims that health professionals are more concerned about physical training. Different clients need different approaches in the goal setting. This is what Hammell (2006) describes as a tailoring approach that each individual requires. At the same time lack of knowledge about health and rehabilitation can cause misunderstanding and pessimistic views of recovery passivity, and limited use of rehabilitation services. One informant explained that she had a woman client from Somalia who was very disappointed as to why she could not bend, but she had a hip fracture. The informant explained that some of the women in Somalia have not been to school and have no knowledge about and rehabilitation in general. It is unclear whether knowledge or education about health and rehabilitation would be helpful without cultural beliefs and practices that are not according to western values. Culture and religion was also observed to have played a central role in the clients' goal setting process. One informant described of a client who saw his situation as the will of God. Whenever given any task all he said was "insha-Allah" (if God is willing). He was placing the responsibility to God. This fatalistic belief was a dilemma for the informant and didn´t know how they would provide help to the clients. This can be related to Hammell´s religious model of disability or impairments. As Thomson (1997) suggests that the human need for resemblance gives rise to a belief that people get what they want or deserve. He further says that if something bad happens to someone like impairments, then there must be a good reason for that. It is like a psychological safeguard against the

intolerable randomness of experience (Hammell 2006 s. 56). I think that the clients spiritually reaction to recover can be seen as a psychological safeguard.

5.3 The problematic of goal setting

The informants' role is often to guide the clients in the process of formulating goals. One informant has experienced that minorities' clients have difficulties in communicating their goals. Borislav from Bosnia believes that some clients have trouble setting their own goals:

> *(…) I cannot remember even once my clients had defined a goal by themselves. It has been more like having to force it out from them. (…..). I think minorities' clients have trouble setting their own goals. May be that word goal does not exist in their language or culture.*

Pernille who is an PT from Norway felt that when it came to goal setting say that:

> *I am an occupational therapist and I am the one who challenges them here with conversations about their goals and what we are going to work forward to. Sometimes we get good structured target goals but not always. (…) One thing I experienced is that sometimes they do not have such much desire.*

Health professionals often guide clients in creating relevant goals. It is important to divide their goals as Mari illustrates this in the statement as follows:

> *It is important to divide their goals in small section, because having big goals can be unrealistic to achieve. For example, if you are sick and want to recover, you must have small goals that you can achieve easy and this can motivate the client to work towards the bigger goal. It is challenge for many, and if you have very unrealistic goals, it will be a challenge. So you have to re-orientate along the way. If you see that the goal is not working then, you have to set new goals. Thinking that way too can be a big challenge.*

Sometimes dividing goals cannot be enough if the word goal is not understood and the motivation is not there. As analysed above the informants experienced that may be the word goal does not exist in the language, some didn´t have desire to achieve goals and informants needed guidance in goal setting by dividing their goals in small section so that it can be achievable.
In the ensuring paragraphs I discuss the experiences of the informants and of what other scholars have said about the issues in goal setting.

According to Normann, Tveit Sandvin and Thommesen (2006), the governmental definition of rehabilitation, it is a process. In a rehabilitation perspective, the term process refers to something specific. The word process in this regard points to the course of progress that the individual is undergoing and the context in which the various instances are included and which are associated with expectations. This process is driven forward by interaction between those who provide assistance, with the aim of achieving development or change. The processes in the context of rehabilitation should, according to the definition, be time-limited processes. This means that timeframes must be set for the process, which enables evaluation of the goals and instruments that are included in the process. The goal of rehabilitation work is to achieve increased participation by regaining function, preserving existing function or slowing down functional capacity. Diversity skills can make it easier to fulfill this template and provide a good facilitation opportunity for the individual. This definition as mention in 3.2 is emphasizes physical activities and independence. Different clients need different approaches in the goal setting. Routines that are established in rehabilitation are more for the homogeneous group and do not always match with adults' minorities' culture. This can create uncertainty and insecurity in their rehabilitation process and be challenging for health profession trying to make the clients achieve their goals. In case of illness or injury, the goal-setting process can be more challenging because the professional and adult minorities have different perceptions of the situation, conflict may occur. On the other side Hammell (2015, 2006) definition of rehabilitation as mentioned in 3.2 as a process of enhancing well-being and of attaining or regaining a meaningful life has been described by her as a tailored approach because it takes individuals into account. She further says that all they want and need rehabilitation interventions is to be tailored to their lives rather than to their bodies. She refers to Bury (1991) who views the usefulness of adult who has impairments or illness as a sign of life disruption. And one that has injuries or impairments has disrupted not only just a body but also an entire life. For adult´s minorities´ coming from a collectivistic culture care

more of recovery than physical activity and are more of interdependence than independence as mention in my analysis.
In the interviews, several informants express that client involvement in their rehabilitation process is difficult. They spend a lot of time stimulating clients to become actively participating in their own rehabilitation process, clients who, for various reasons, refuse or do not want to participate. Is it in practice that health professions strive to get clients to participate actively or is it health professionals who limit the clients' ability to participate? Can both be equally relevant at the same time or are there other reasons when it comes to to adults´ minorities' clients? Some of the informants blame on the extreme family involvement and other blame on their culture. The home care reablement the clients' rehabilitation takes place in their homes. Home care reablement is a resource-oriented work that emphasizes the person's health and resources, rather than illness and limitations. Even though home care reablement is seen as elements of health promotion and disease prevention, but still home care reablement is considered to be primarily a rehabilitative form of work (Tuntland and Ness, 2014).

In the definition of rehabilitation as seen before (in 3.2), it is a clear requirement that clear goals should be specified for the individual clients. Goal setting is the main focus of rehabilitation (Playford, Siergert, Levack & Freeman 2009). Playford et al. (2009) refers to Locke and Latham (2002), which describes that self-determined goals are always the most effective. The informants presented a number of challenges when it came to goal setting. All of the informants in my study said that it was their role through dialog to guide the clients to achieve good goals. As one health profession explained that she was the one who challenged them with conversation about their goals. Sometimes good structured goals were targeted but not always. The informants experienced that some clients had big and perhaps unrealistic goals. They regard it as their responsibility to make the goals more realistic. At the same time, several informants talked about the importance of not taking the clients dreams or hopes on the road to realistic goals. There may be conflict in goal setting between health personnel who want specific goals and clients who want general longer-term goals. It then can be a dilemma for health professionals as the client sets goals than we as is not achievable as soon as they want or may be never. One informant explained that after one has had stroke one couldn't necessarily be as before. She further explains that it is very important to divide their goals into small section because having big goals could be unrealistic to achieve. If one wants

to recover then it was important to have small goals. And so one has to re-orientet all the time, but this was challenging too.
Sugavanam, Mead, Bulley, Donaghly & Van Wijck (2013) describe goal setting work as the client self-concerned with entirety. The goals that the client himself or herself puts is often long-term and related to hope. Hope to be as before he or she was sick. At the same time one informant explain that sometime the client had no desire to achieve this goals. Locke & Latham (2002), describe that it is more important that the goals are ambitious than they are achievable. The biggest challenge that was experienced with one of the informant was that most of his clients could not even define goals by themselves. He said that he had to force it out of them. He thought that might be the word goal did not exist in their language or culture. This was very challenging for the informant. Despite the challenges health professionals meet in home care reablement for adults´ minorities, is still important that the services they are providing to the client is meaningful.

5.5 Cultural awareness

Having a cultural awareness towards adults´ minorities will enhance positive outcome despite the difference in culture. Despite that, almost all the informants experienced and emphasized that understanding adult´s minorities' expectations is more important for achieving goals as a general focus in rehabilitation. That would be more of cultural relativism approach rather than ethnocentric approach.

Borsilav from Bosnia explains that when it comes to cultural awareness one can sometimes experience a kind of friction, that your time is not being used efficiently enough. Eventually you use extra time to accommodate this group of clients. But this can be positive because their needs get a little more explanatory. He further says that one need to be more cautions of their own prejudices because we all have it. Borislav emphasizes that:

> *It is very important to have an open eye, active thoughts and a view about others culture.*

Borislav always felt that whenever he left their home, they were always on his mind. He says it is kind of a barrier but also a resource.

When asked how health professions can do to provide help based on understanding clients culture. Mari from Norway says:

> *It is important that you put yourself in their situation and know where they are from. Because I think, one must relate to the duties of the country where you live. Once you get sick you get very vulnerable and mentally one goes a little bit back from the start. I am from Scandinavia but not from Norway and I know very well how it is to live somewhere else. You may not understand everything that happens around you. So it is very important to spend time, and try to check out if one has been understood.*

But Mari admits that sometimes it is hard to put yourself in their situation. She says:

> *I have an example of a man from Afghanistan. He felt that he was not met on his cultural values. We worked so on this issue, I remember we had a lot of meetings with him, relatives and health workers. We even had an interpreter to explain the facts and how we saw and experienced things. And we had to explain why we did this and that but I think we let it go too long because we were very kind.*

But Mudagazi from Zimbabwe explains that in order for health professionals to achieve cultural awareness they need to think out of the box and not only concentrate in what they have read in theory because theory and practice is not the same. But the most important thing is for health professionals to build trust with the clients, but it can be a challenge due to language barriers.

Most of the informants experienced challenges with communication because most of the clients could not speak Norwegian at all. The informants said that sometimes it was not easy to get translator at that moment, so they could sometimes use work colleagues of minorities' background to communicate with the clients. Mari says that one of the biggest challenges is communication. Most of the clients cannot speak or express themselves in Norwegian language. She says:

> *There are many challenges that may happen when trying to help them set goals. Some of the clients have been traumatized before. Their thoughts are the hardest challenge*

because you cannot take people from their experiences. At the same time there is the communication issue where you simply cannot communicate. So it becomes difficult to get into the problem if you can only communicate with a smile and some words.

Tanya from Norway says that:

It is clear that when you meet others with different backgrounds, there may be also communication issues or challenges due to language differences.

Some of the informants meant that the clients had trust issue too due to language barriers. Borislav says that:

The clients have trouble trusting health professions if they don´t understand whatever that is said. But because of language barriers then one has to work hard to build trust.

Amina from Somalia adds that:

Trust issues can occur with some clients due to language barriers: But then it is important to build trust with each other.

But Pernille from Norway says she found trust issue to be challenging because it was not only because of language barriers but also cultural belief. She says:

I remember that there was a male client who had trouble trusting my colleagues and me because we were young girls. We were at the same age as his children. It was a little challenging because I felt what he saw was young girls and not health professionals. I think this is may be a cultural belief.

Informants meant that in order to achieve cultural awareness one should have an open eye, the importance of knowing who they really are and putting yourself in their situation and know where they are from. The scholars provide too an opinion on this subject that I discuss in the next paragraph.

The attitude to health professionals towards adult´s minorities in rehabilitation process is important. If health professionals lack knowledge about other cultures, it may be easy to leave their own frame of reference take control over interaction with the minorities culture. Health professions have explained their experiences in home care reablement for adults´ minorities as a challenge and sometimes they found themselves in a dilemma. One of the informants said that in order for health professionals to achieve cultural awareness they need to think out of the box. For her theory and practice were two different things. What you read in books cannot be the same with what one experiences in practice or at work. As mentioned in 3.1 Hammell (2006) suggested that theories are more of formalized ideas and how one thinks determined what one thinks. Whatever much theory one has learned about minorities' clients' can be different with what one experiences in practice. Jensen & Ulleberg, (2011), suggest that when a professional who comes from individualistic culture meets a client who belongs to a collectivist culture, it is important that they take the time to find a way to cooperate on what is good for both parties. In such situations, the professional must always take the time to ask the necessary questions and listen to what is going to create a good situation or a good schedule for a work that will go over time.

From culture to culture, there are different ways that people move toward completing tasks. It is impossible to put yourself in one situation. Only the person in that situation can understand better where he or she stands with their situation. This can be seen as interpretative thoughts trying to have pure cultural attitude. This aspect is made visible through one of the quotes to one of the informants "*it is important that to put yourself in their situation and know where they are from".* Eriksen and Sajjad (2006) say that neither a pure ethnocentric or a purely cultural relativist attitude is possible or desirable in practice. Furthermore Brodtkorb and Rugkåsa (2009) suggest that ethnocentrism implies briefly that someone's actions are based on their own interpretative framework and thus reserves the right to decide whether they are good or bad, correct or wrong. It is important that health workers should avoid using their own culture as standard. As one informant stated that "*but I think we let it go too long because we were very kind".* The informant felt their routines and standards were challenged. But at the same time this can be seen as an ethnocentrism practice because the goals that are to be achieved should be on clients' premises.

Goal setting requires trust and good communication between the clients and health professionals. The informants explained that they were challenged with communication problems due to language barriers. But it is an obligation for the informants to assure that clients understand them. One informant says that that sometimes they only communicated with smiles. On other side Jensen & Ulleberg, (2011), emphasized that people, in contrast to the animals, communicate through symbols, and that through symbolic communication we can take the others' perspective. So one does not actually need to use words to be understood. Moreover, it becomes difficult to build a relationship when one knows that the client cannot communicate the basic and necessary information.

Generally without communication there will be no trust in a relationship. Almost all clients claimed that trust issues was because of language barriers. It requires that the communication builds trust and that they meet the clients with respect, as well as provides the clients with the ability to reach the goals. Health professionals have experience in the field and have the knowledge that clients need. Then they must appear credible. Trust can be based on knowledge and expectations about the people and situations in which it is included. However, it can also "bridge" in the absence of knowledge of the one receiving trust. Trust also facilitates the transfer of knowledge and information by avoiding control of the other says if you trust them (Grimen 2009).

According to research on cultural awareness, health professions need to keep in mind that everyone has his/her own values, beliefs, and assumptions that influence healthcare. In addition, clients from different race, ethnicity, gender, and religion response to health care services differently. Therefore, they need should provide tailored individualized care that meets the needs of their clients.

6.0 Concluding comments

In thesis I asked what type of challenges did health professionals face in rehabilitation of adult´ minorities in home care reablement. The study presented five main themes: Challenges between culture, interdependence and not independence, expectation on recovery, problematic with goal setting and cultural awareness.

The first main theme states that there is cultural diversity in home care reablement that has been challenging for health professions. There was diversity in culture such as gender, food and hygiene. There was a big difference between individualistic culture that is practice in Norway and the collectivist culture that is practiced by the adult minorities when it came to these aspects. Female clients expected female health professions to attend to them and vice versa. Health profession meant that it was sometimes difficult to meet their needs.

The second theme was interdependence and not independence. Health professionals explained how the family was also seen as a central influence on the individual. Family involvement was seen for some of the informants as both as an inhibitory and facilitator. Some felt that the family being always there was not motivating to the clients. These were particularly highlighted with adults´ minority where the perceived rules of family engagement were not fully understood by the professionals. But the health professions found out was that it was part of their culture for their families to take care of them and that the fact that lots of family members lived under one roof. Some informants thought it was good to have families around because it could motivate the client to be independent.

The third theme was the expectation of recovery the clients had. The informants said the minorities' clients had high expectation when it came to recover and they expected to recover and be as before they were sick. The concepts of the "expert" to "fix things" were raised. More specifically the fatalistic beliefs and the concept that "if God's will" was seen to significantly influence the process of recovery.

The fourth theme was problematic with goal setting. The definition of rehabilitation is formed for homogeny clients, while the adults´ minorities come from heterogenic culture. Due to different culture goal setting was challenging for clients to achieve. Clients come from collectivistic culture where they depend on others and this made it difficult for them to

communicate their goals. One informant even thought that might be the word goal didn´t even existed in their language and culture. The clients had long- term goals that were impossible to achieve such as to recover fully. The fact that they have high expectation when it comes to recovery limits the motivation to set goals that can be achievable.

The last theme was cultural awareness. The informants expressed how important it was for them to have a cultural relativism approach when it came to adult´ minorities. They believed this could enhance positive outcomes, however, it was not easy as for most of them their situation seemed to be more of ethnocentrism approach rather than cultural relativism. In order or the health professional to have a cultural relativism approach they need to communicate with the clients and build trust with them.

All the five themes show the experiences or reflections health professionals have about adult´ minorities' expectation of home care reablement when it comes to achieving goals and culture.

Many of the findings found in the study are recognizable both in relation to what the informants experience as challenging at the home care reablement for adults´ minorities and solutions they outline to overcome these challenges. By analyzing the empirical material in light of the theory of culture, health and culture, rehabilitation, home care reablement and goal setting there has been an increased understanding and awareness of the subject with me as a researcher.

It appears there a need for increased multicultural competence and more people with minority backgrounds to work in health and social services a as they would have better prerequisites for understanding the cultural and religious background of adult´ minorities. And in order to offer culturally appropriate care, these issues should be taken into account during the rehabilitation of adult´ minorities.

7.0 References

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Appendix 1

Information Letter

Dear participant

Request for participation in the research project " What is the challenges that health professionals face in rehabilitation with Adults' minorities in home care reablement and how this experiences can be understood"?

Background and purpose of study

Oslo, 20.02.17

There are many reasons why it is important to have knowledge of challenges that occur in the rehabilitation of adults´ minorities in home care reablement. Health professional's worker's meet minorities' clients with a different ethnic background, this can create uncertainty if they have little or no knowledge of their culture, being and mind set. This will mean major challenges for the reorganization of the care services of this group. In order to provide comprehensive rehabilitation and to meet their needs, it is, therefore, necessary to have knowledge of these clients' matters that are important to them. It will also contribute to our knowledge about an area for development of cultural competence. It will also promote a cultural relativism approach, which can give better outcome.

What does the study mean?

If you would like to participate in the study, you will be offered an opportunity to participate in an interview. It is a semi-struck interview with which one talks about his experiences in relation to the chosen topic. It will be used tape recorder interview. The information that is registered should only be used as described for the purpose of the study. All information will be processed without name and personal identification number or other directly identifiable information.

Voluntary participation

It is voluntary to participate in the study. You can at any time, without giving any reason, withdraw your consent to participate in the study. If you wish to participate, you sign the consent statement on the last page. If you say yes, you can withdraw your consent later. If you later wish to withdraw or have questions about the study, please contact Master Student Mona Samantar at 96232987.

Right to access and delete information about you and delete samples

If you say yes to participate in the study, you have the right to gain access to what information is registered. You also have the right to correct any errors in the information I have registered. If you resign from the study, you may require deleted information collected, unless the information has already been included in analyzes or used in scientific publications.

Information about the outcome of the study

As a participant you have the right to get information about the outcome of the study.
With best regards
Mona Samantar
E-mail: s236866@

Mobile: 96232987

Consent for participation in the study

I am willing to participate in the study

---------- ---------- ------ ----

(Signed by project participant, date)

I confirm that I have provided information about the study

--- --- ------ ---

(Signed by Student: Mona Samantar, date)

Appendix 2

Interview guide

Introduction:

Present me self and my project.

Inform interviewee that the interview will be taped and transcribed.
Inform that the informant is assured anonymity and confidentiality both orally and simultaneously provide written informed consent.

Questions about the informant:
Can you tell me about what you work as and how long you have worked with (cultural minorities' patients in rehabilitation?

What refelections do health professionals have about adults' minorities' expectation when it comes to rehabilitation?

- Can you tell me of an example of a first meeting with a client with minority background, how did you proceed to gain knowledge about this clients´ cultural background?
- What is your general opinion about your clients' reactions and expectations to the treatment?
- Is their any difference between minorities' clients (from Pakistan, morocco or somalia) and Ethnic Norwegians clients when it comes to expectation about treatment, being independence, families' roles etc?
- Can you tell me example of a client (at the last meeting with your client) that has had positive (or negative) comment to treatment, to goal of being independent, or being in need of help, care etc. Have you experienced any challenges?

Rehabilitations goals are to make the client to achieve independence in their lives.

What experiences do health professionals have when it comes to challenges adult minorities encounter achieving goals in rehabilitation?

- Can you give an example of where your client/clients have had problems making/achieving goals?
- Can you give an example of where your client/clients have had no problems making/ achieving goals?
- Do you have clients that are concerned about managing themselves and those that are more concerned about getting help? (If yes give an example)
- What are the most important three things that you would take into account in mapping measures for minorities' clients?

What can health professionals do to provide help based on an understanding of adults minorities culture?

- Have you meet challenges when it comes to minorities due to cultural differences. Where can you get help
- Do the minority client experiences that they can live their lives in accordance with their cultural values here in Norway. Give me an example of success and of where there is a dilemma.
- When do they feel respected or disrespected when it comes to their values and culture?
- Can you give an example where cultural values were not meet and why was it that way?
- What factors do you think are important to take into account to provide assistance according to their needs?
- Have you experienced clients having problem with trusting you as a health professional. (If yes how did you gain their trust)?

Are you and your colleagues offered specific courses to deal with multicultural society? Do you discuss the topic in your team, at your team meetings?

Are there other aspects you would like to illustrate that you feel has not been asked or answered?

Appendix 3

Inger Marie Lid
Høgskolen i Oslo og Akershus,
Postboks 4, St. Olavs plass
0130 OSLO

Vår dato: 02.01.2017 Vår ref: 51361 / 3 / KH Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 30.11.2016. Meldingen gjelder prosjektet:

51361	*Quality studies about cultural influences in rehabilitation of elderly minorities with impairments*
Behandlingsansvarlig	*Høgskolen i Oslo og Akershus, ved institusjonens øverste leder*
Daglig ansvarlig	*Inger Marie Lid*
Student	*Mona Samantar*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 16.09.2018, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Kjersti Haugstvedt

Kontaktperson: Kjersti Haugstvedt tlf: 55 58 29 53

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Vedlegg: Prosjektvurdering
Kopi: Mona Samantar muuna_2006@hotmail.com

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 51361

The sample will receive written and oral information about the project, and give their consent to participate. We find the letter of information well formulated.

The Data Protection Official presupposes that the researcher follows the requirements of Høgskolen i Oslo og Akershus regarding data security.

Estimated end date of the project is 16.09.2018. According to the notification form all collected data will be made anonymous by this date. Making the data anonymous entails processing it in such a way that no individuals can be recognised. This is done by:
- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable data (i.e. an identifying combination of background variables, such as residence/work place, age and gender)
- deleting audio files

Appendix 4

BEKREFTELSE PÅ ENDRING

Hei, viser til endringsmelding registrert hos personvernombudet 23.03.2018, med rettelse mottatt 04.05.2018.

Vi har nå registrert at ny prosjekttittel er ”Qualitative studies of Collectivistic rehabilitation in Home-care reablement of Adult´ minorities”.

Vi legger til grunn at Marte Feiring er ny veileder og daglig ansvarlig for prosjektet, jf. e-post sendt 04.04.2018.

Personvernombudet forutsetter at prosjektopplegget for øvrig gjennomføres i tråd med det som tidligere er innmeldt, og personvernombudets tilbakemeldinger. Vi vil ta ny kontakt ved prosjektslutt.

Vennlig hilsen,
Øivind Armando Reinertsen
Rådgiver | Adviser
Seksjon for personverntjenester | Data Protection Official
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