

**Growing Old amongst Strangers and Staying Healthy, As
Experienced by Elderly Sri Lankan Immigrants Living in
Norway**

H.R. Ajith Senake Goonetilleke



Masteroppgave ved Institutt for sykepleievitenskap og helsefag

UNIVERSITETET I OSLO

Mai 2011



UNIVERSITETET I OSLO
DET MEDISINSKE FAKULTETET
Institutt for sykepleievitenskap og helsefag
Boks 1153 Blindern, 0318 Oslo

Navn: **H.R Ajith Senake Goonetilleke**

Dato: **Mai 2011**

Tittel og undertittel: Gammel blant fremmede. Hva opplever eldre Srilankiske innvandrere bosatt i Norge som god helse?

Sammendrag:

Formål: Hensikten med studiet er å kartlegge hva eldre Srilankiske innvandrere bosatt i Norge opplever som god helse. Hva mener de med god helse? Og hva gjør de for å ta vare på helsa si. Målet med studiet er å skaffe ny sykepleiekunnskap som kan sette sykepleieren i stand til å yte kultur tilpasset omsorg i samsvar med den eldre Srilankiske innvandrers kulturelle behov.

Teoretiske forankring: Leiningers (1995, 2001) teorien om kultur betinget omsorg er brukt som hovedreferanseramme. Målet med teorien er å gi kulturell relevant bakgrunnskunnskap om helse og omsorg som kan sette sykepleieren i stand til å yte omsorg i samsvar med klientens kulturelle behov, verdier, forestillinger og daglig leveste. Kultur, helse og sykdom som forklart av Helman (2000) har også blitt sett på fordi det virket relevant for å gi en bedre forståelse av begrepet kultur i forhold til helse.

Metode: Dette er en kvalitativ studie. Convenience purposive snowball sampling (Polit og Beck, 2004) var brukt til å rekruttere syv informanter. Data ble samlet inn ved av en semi-strukturert intervju og senere analysert med en template analyse (Polit og Beck, 2004) stil.

Resultater: Mens det er få likheter med den norske kulturen om hva de mener og hva de gjør for å ta vare på helsa si, er det merkbart flere ulikheter mellom kulturene.

Konklusjon: Sykepleiere og helsepersonell som ikke kjenner til disse kulturelle behovene, verdiene, forestillingene og leveste, vil mest sannsynlig ikke kunne yte kulturbetinget omsorg til disse eldre klientene.

Nøkkelord: Gammel fremmede, eldre Srilankiske innvandrere i Norge, god helse, kulturbetinget omsorg



UNIVERSITETET I OSLO
DET MEDISINSKE FAKULTETET
Institutt for sykepleievitenskap og helsefag
Boks 1153 Blindern, 0318 Oslo

Name: H.R Ajith Senake Goonetilleke

Date: May 2011

Title and subtitle: Growing Old Amongst Strangers and Staying Healthy, As Experienced by Elderly Sri Lankan Immigrants Living in Norway

Abstract:

The purpose of this qualitative study has been to investigate the meaning and practices of staying healthy as experienced by elderly Sri Lankan immigrants living in Norway.

The aim and goal being to obtain new knowledge that could help nurses and the Norwegian health sector provide culturally congruent care to elderly Sri Lankan immigrants

The theoretical reference frame: The study is guided by Leininger's (1995, 2001) Culture Care Theory. Leininger (2001) predicts that specific culture, health and care knowledge gained from using the culture care theory would give a wealth of information that would help achieve the goal of the theory. That is to make nursing care decisions and actions that are culturally congruent with the beliefs, practices, and values of the life ways of the clients. The theory and study has a trans-cultural focus. With a trans-cultural focus according to Leininger (1995, 2001), nurses think about culture care differences (diversity) and similarities (universality) across cultures in order to assist people to attain and maintain meaningful and therapeutic health care practices that are culturally based. Culture, health and illness as viewed by Helman (2000) too has been looked into as it seemed relevant in further understanding the concept of culture in association to health.

Design and Method: This is a qualitative study conducted in 2005/2006. Convenience purposive snowball sampling as described by Polit & Beck (2004) was used to recruit seven informants. Data collection is based on a qualitative semi structured interview guide. To make sense of the data collected a template analysis style (Polit and Beck 2004) was applied.

Findings and Conclusion: While a very few similarities exist, there are more significant differences exhibited by Sri Lankan elderly immigrants compared to the Norwegian elderly in their meanings and practices of staying healthy. Nurses and health care professionals who do not recognise these significant similarities or differences might not possibly be able to offer culture congruent care that maintains or improves the Health and well being of these elderly clients.

Key words: Growing old, Sri Lankan, elderly immigrants in Norway, culture congruent care, meaning, practice, staying healthy, experience.

Acknowledgements

There are many whom I would like to thank, but there are a few who need special mention. First my grateful thanks go to the members of the Sri Lankan elderly community living in Norway who I met and interviewed. Thank you for your precious time, patience and interest.

Thank you to my close relatives, friends and colleagues who motivated and inspired me to go on as well as those who doubted me at times. Your doubts inspired me more.

Special thanks to Professor Bodil Ellefsen and the administrative staff at ISV for their patience, kindness and tolerance extended right through out.

I would like to say a big thank you to my wife Charlotte and my two daughters Amanda and Caja for their immense patience and sacrifices. Your help and support I could not do without.

Finally I say thank you to mum and dad, you two have been my biggest inspiration.

Whilst working on this paper, military operations in the Northern regions of Sri Lanka ended on the 19th of May 2009. The Sri Lankan Armed Forces defeated the military wing of the LTTE. Its leader Velupillai Prabhakaran was killed bringing to end an almost 30 year long armed conflict. The armed conflict may have ended but the psychological scars left on most minds may be difficult to erase to those both living in Sri Lanka and it's migrants as the final stages of the war resulted in many deaths and displaced almost another 250.000 people, of all ages. Thus, I dedicate this paper to those people who did not make it to safe heavens, especially the old and the feeble of all Sri Lankan communities who sacrificed their lives during the conflict. I hope their lives were not lost in vain.

TABLE OF CONTENTS

1.0 INTRODUCTION	1
1.1 BACKGROUND AND PROBLEM	1
1.3. PURPOSE AND GOAL	2
1.4. THE RESEARCH QUESTIONS AND HYPOTHESIS	2
1.5. DISPOSITION OF THE PAPER.....	3
2.0. CULTURE, HEALTH AND TRANS-CULTURAL ASPECTS OF NURSING	4
2.1. CULTURE	4
2.2. HEALTH	5
2.2.1 <i>Professional and lay perspectives of health</i>	5
2.2.2 <i>Lay theories of illness causation</i>	7
2.2.3 <i>The three systems of health care</i>	10
2.3 TRANS-CULTURAL NURSING AND CULTURE CARE THEORY.....	11
2.3.1 <i>Trans-cultural nursing</i>	12
2.3.2 <i>Culture Care Theory / Theory of Culture Care Diversity and Universality</i>	12
2.3.3 <i>The Sunrise Model or Enabler to discover Culture Care</i>	14
3.0. SRI LANKA: A GEO HISTORICAL GLIMPSE, IT'S ELDERLY, HEALTH SERVICES, SYSTEMS OF HEALTH CARE AND CARE FOR THE ELDERLY. THE MIGRATION OF SRI-LANKANS TO NORWAY AND ELDERLY IMMIGRANTS IN NORWAY	19
3.1. GEO HISTORICAL GLIMPSE OF SRI LANKA.....	19
3.1.1 <i>Environment</i>	19
3.1.2 <i>History</i>	19
3.1.3 <i>Its People</i>	20
3.1.4 <i>The conflict</i>	22
3.2. CHARACTERISTICS OF THE ELDERLY IN SRI LANKA, HEALTH SERVICES, SYSTEMS OF HEALTH CARE AND LONG TERM CARE FOR THE ELDERLY	23
3.2.1 <i>Old age Defined</i>	23
3.2.2 <i>Life expectancy, health, family situation and marital status</i>	24
3.2.3 <i>Health services, beliefs and practices</i>	24
3.2.4 <i>Long term care for the Elderly</i>	27
3.3 THE MIGRATION OF SRI LANKANS TO NORWAY	29
3.5 <i>How elderly immigrants experience their situation in Norway</i>	30
4.0. THE METHOD	35
4.1. THE STUDY'S DESIGN	35
4.2. RECRUITMENT OF INFORMANTS	36
4.3. DATA COLLECTION	37
4.3.1 <i>Formulation of the interview guide</i>	37
4.3.2 <i>The language</i>	38
4.3.3 <i>The site of the interview</i>	38
4.4. DATA ANALYSIS	38
4.4.1 <i>Analysis style</i>	38
4.4.2 <i>Analysis during data collection</i>	39
4.4.3 <i>Transcribing</i>	39
4.4.4 <i>The analysis proper</i>	39
4.5. ETHICAL ASPECTS	41
5.0. PRESENTATION OF THE FINDINGS	42
5.1 ECONOMIC MEANS AND HEALTH.....	42
5.1.1 <i>Maintaining economic success</i>	42
5.2 EDUCATION	44
5.2.1 <i>Achieving educational success</i>	44
5.3 KINSHIP AND FAMILY STRUCTURE	45
5.3.1 <i>Maintaining friend and family support</i>	45
5.4 VALUES, BELIEFS & LIFE WAYS IN STAYING HEALTHY	49
5.4.1 <i>Maintaining beliefs, behaviours and activities that facilitates health</i>	49

5.5 SPIRITUAL AND PHILOSOPHICAL DIMENSIONS OF STAYING HEALTHY	58
5.5.1 <i>Maintaining spiritual and supernatural beliefs</i>	58
5.5.2 <i>Staying healthy is how we live and behave</i>	59
5.5.3 <i>Meditating</i>	59
5.6 POLITICAL AND LEGAL FACTORS	60
5.6.1 <i>Following developments back home and longing for the former way of being</i>	60
5.6.2 <i>Having a proper job and not being discriminated</i>	61
5.7 TECHNOLOGICAL FACTORS	62
5.7.1 <i>Having access to the internet means staying healthy</i>	62
5.7.3 <i>Maintaining mobile phone communication with ones family</i>	63
6.0. DISCUSSION.....	64
6.1 ECONOMIC MEANS AND HEALTH.....	64
6.2 EDUCATION	67
6.3 KINSHIP AND FAMILY STRUCTURE	70
6.4 SPIRITUAL, PHILOSOPHICAL DIMENSIONS, CULTURAL VALUES, BELIEFS AND LIFE WAYS OF STAYING HEALTHY	76
6.4.1. <i>Maintaining spiritual and supernatural beliefs</i>	76
6.4.2. <i>How We Live and Behave</i>	77
6.4.3. <i>Religion and diet</i>	78
6.4.4. <i>Health maintaining beliefs and practices</i>	79
6.5 POLITICAL & LEGAL FACTORS	85
6.6 TECHNOLOGICAL FACTORS	88
7. SUMMARY, RECOMMENDATIONS AND CONCLUSION.....	90
7.1 SUMMARY	90
7.2 RECOMMENDATIONS	93
7.3 CONCLUSION	95
REFERENCES	96
APPENDIXES	I
APPENDIX 1: ETHICAL CLEARANCE 1	I
APPENDIX 2: RESPONSE TO ETHICAL CLEARANCE 1	III
APPENDIX 3: INQUIRY TO PARTICIPATE	V
APPENDIX 4: LETTER OF CONSENT 1.....	VII
APPENDIX 5: ETHICAL CLEARANCE 2	VIII
APPENDIX 6: LETTER OF CONSENT 2.....	IX
APPENDIX 7: INTERVIEW GUIDE	X
 Figure 1: The Sunrise model or enabler.....	 18

1.0 INTRODUCTION

1.1 Background and Problem

In 2005, only a meagre 131 Sri Lankan immigrants in Norway were over the age of 67 whilst just 218 Sri Lankans were within 50-66 years of age (Statistisk sentralbyrå, 2004). In total there were 11,475 Sri Lankan immigrants within all age groups, which means the health sector in Norway would have to face up to a growing number of elderly from this ethnic group too. However, there appears to be a great lack of nursing knowledge with regard to this particular group of elderly. Looking through electronic search tools such as Ovid full Text, MEDLINE and CINAHL, no nursing research was traced internationally or in Norway with regards to Sri Lankan elderly immigrants' or their health and care beliefs and practices at the commencement of this study. Just a few associated international research articles (not nursing) were traced: "The status of South Asia's growing Elderly population" (Martin, 1990) which included the rest of the South Asians too, "Population trends in Sri Lanka: Implications for the family and elderly" (Perera, 1999), a "Case study Sri Lanka" (Abeykoon, 2002), "A preliminary study of the hospital-admitted older patients in a Sri Lanka tertiary care hospital" (Weerasuriya and Jayasinghe, 2005), and " Socio-economic implications of ageing in Sri Lanka: an overview" (Siddhisena, 2005). Brief looks into some of these studies are done in section 3.2 and 6 of this paper.

Studies in Norway are largely limited to the description of health values, beliefs, practices or needs of Asians in general with a greater emphasis given to the bigger ethnic groups such as Pakistani's or Muslims (Birkeland, 1990; Baluyot, 1999; Blom and Ramm, 1998; Dawes and Thoner, 1997; Moen, 1993; Moen, 2002). These studies are looked into in section 3.5 and chapter 6 respectively.

Competent provision of culture congruent care requires the development of a genuine understanding of how people from other cultures maintain their health and well-being (Leininger, 2001). This leads to the question whether Norwegian nurses have available information and the knowledge required to offer competent culture congruent care to Sri Lankan elderly immigrants living in Norway to maintain their health and well-being?

The meeting of the Sri Lankan elderly immigrant and the Norwegian nurse or health system is a meeting between two cultures. Each party brings to the meeting a history of culturally embedded knowledge, values, beliefs and practices that shape each others expectations and behaviour in maintaining ones health and well-being. Generally nursing

and the health services are formed by the norms of the majority or local culture and available knowledge. Thus, there may be little room for the tolerance and accommodation of other approaches if little is known which could easily lead to misunderstandings in situations of care.

1.3. Purpose and Goal

Thus, the purpose of this qualitative study is to investigate the meanings and practices of staying healthy as experienced by elderly Sri Lankan immigrants living in Norway. Further, the intention is to gather culture specific health and care knowledge that could guide or improve present day nursing care practices. The aim is to discover, describe and discuss as to which cultural values, beliefs and practices are most meaningful to these clients for maintaining or experiencing health and well-being at an old age. Finally, the goal of this study is to provide culturally congruent and competent nursing care that would maintain or lead to the Elderly Sri Lankan immigrant's health and well-being.

The theory of Culture Care Diversity and Universality developed by Leininger (1995, 2001) provides the main theoretical framework to guide the study. Culture, health and illness viewed by Helman (2000) too has been looked into as it seemed relevant in further understanding the concept of culture in association to health which is the main focus.

1.4. The research questions and hypothesis

The two central questions in this study are; how is the experience of staying healthy lived by elderly Sri Lankan immigrants in Norway? And what is the meaning of staying healthy for the informants?

The theory of Culture Care Diversity and Universality rest on many theoretical premises and assumptions which are used to describe, explain, predict, and interpret nursing phenomena. The following premises are used to guide this study;

- Sri Lankan culture has specific health care values, beliefs and practices that influence Sri Lankan elderly immigrants' meanings and practices of staying healthy.
- These health care values, beliefs and practices are influenced by and tend to be embedded in their Religious & Philosophical Beliefs, Kinship & Social Structures, Cultural Values & Life ways, Political & Legal Dimensions, Economic Factors, Educational back grounds, Technological factors and Ethno Historical Context of their culture.

- Knowledge obtained of the health care meanings and practices that influence Sri Lankan Elderly immigrants' well-being and health status can guide nurses to provide or improve culturally congruent professional care practices in Norway to this group of elderly in situations of care.

1.5. Disposition of the paper

Chapter 1 introduces the background and problem, purpose and goals, research questions and hypotheses.

Chapter 2 determines health in association to culture. Perspectives of health and illness, lay theories of illness causation and the three sectors of health care that are used at time of illness are described. Trans-Cultural Nursing and the Culture Care Theory followed by the Sunrise model or enabler that guides this paper are presented.

Section 3.1 gives a geo-historical glimpse of Sri Lanka, its people, and the ethnic conflict. Section 3.2 first defines the term old and then looks into the situation of the elderly in Sri Lanka. The health systems available, believed and practiced, and the care offered to the elderly to maintain their health and well-being are also looked into. Section 3.3 views the migration of Sri Lankans to Norway, whilst section 3.4 looks at the characteristics of elderly immigrants in Norway in general based on literature and studies available.

Chapter 4 incorporates descriptions and reasons for the methodological choices undertaken in this study. The study's design, recruitment of informants and data collection is explained. The steps applied and methods attempted in the process of analysis of the data are described. By trying to shed light on what has been done and happened during this study, the issue of validity and reliability is attempted to be exposed and secured. Ethical aspects and issues too are highlighted.

In chapter 5 the findings are presented. The themes are organised around the social structure dimensions of Leininger's (1995, 2001) sunrise model that the theorist claims influences peoples meanings and practices of staying healthy. Namely;- Economic Means, Education, Kinship and Family Structure, Values, Beliefs and Life ways, Spiritual and Philosophical Dimensions, Political and Legal Factors, and Technological Factors.

In chapter 6 the study is discussed. The discussion tries to bring to light a window of new knowledge which may be lacking in order to offer culturally congruent care to this group of elderly.

Chapter 7 Summarises the study, recommendations are made and conclusions are drawn.

2.0. CULTURE, HEALTH AND TRANS-CULTURAL ASPECTS OF NURSING

2.1. Culture

According to Leininger (2001), and Leininger and McFarland (2006), “culture is the values, beliefs, norms and practices of a particular group that are learned and shared and that guide thinking, decisions and actions in a patterned way and often intergenerationally” (Leininger and McFarland, 2006, p.13). The related assumption is that the values, beliefs, and practices for culturally related care are shaped by, and often embedded in “ the worldview, language, religious (or spiritual), kinship (social), political (or legal), educational, economic, technological, ethno historical, and environmental context” (Leininger, 2001, p. 45) of the culture. These components of culture perform separate functions but also interconnect to form an operating whole. Culture is viewed in a total social context to understand culture and the meanings assigned to culture specific behaviour such as care. While the concepts of culture and care are central in her work, the concept of health is studied in relation to culture and care. The modes of care values, beliefs and practices exhibited by various cultures are seen as influencing the holistic health and well-being of people. Thus, these care beliefs, values, and practices of cultures are also predicted to be powerful explanatory means to discover and understand health as well as to explain or predict illness conditions.

Helman (2000) defines culture as “a set of guide lines that individuals inherit as members of a particular society” (Helman, 2000, p.2). These cultural guide lines tell people how to view and experience the world. Culture provides people with a way of passing down these guide lines to the next generation by the use of symbols, language, art, and rituals. Helman (2000) explains that to some extent culture could be seen as an inherited lens with which the individual perceives and understands the world which one lives in. A persons beliefs, behaviour, perceptions, emotions, language, religion, rituals, family structure, diet, dress, body image, concepts of space and time, attitudes to illness and pain and other forms of misfortune all of which have important implications to health and well-being are highly influenced by one’s cultural background says Helman. However, Helman (2000) also advices that the culture into which an individual is born into is only one of many influences on health related beliefs and behaviours. Individual, education, socio-economic and environmental factors are also said to influence one’s beliefs and practices. However, all these factors will play some role but in different proportions. Thus depending on the situation it is assumed that at times people will act more culturally than at other times.

2.2. Health

The WHO uses the following criteria in its definition of health:

A state of complete physical, social and mental well-being and not merely the absence of disease, or infirmity

Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities

(Laake, 2003, p.22)

This definition and criteria is meant to be applied to all cultures in both developed and developing countries, to both sexes and all ages where health is meant to be a cumulative state, to be promoted throughout life in order to ensure that the full benefits are enjoyed also in later years (WHO, 2001). However, although the WHO's definition incorporates wholeness, sets high standards to be achieved and has inspired many a nation's definition of health world over, it has been criticized for its idealism, for specifying a state of being which is impossible to achieve (Aggleton, 2003). Aggleton (2003) and Hanssen (1998) say that if an individual is to enjoy the full benefits of a state of complete physical, social and mental well-being, then one should have the resources to meet one's basic needs. In today's world, many people are not in a position to fulfil these basic needs, especially the weak and vulnerable. The definition is criticised for having a western stance of health in its formulation. It was formulated in 1946 (Aggleton, 2003) just after World War II and is accused of having a vision of a world full of optimism free of wars and suffering from a western perspective. It is also criticised for omitting other religious and philosophical aspects that influence health and well being (Aggleton, 2003; Hanssen, 1998).

Aggleton (2003), Helman (2000), Kleinman (1984) and Leininger (2001) generally classify health into two broad types: Official definitions or the views of doctors and health professionals and lay beliefs or views of the non professionals. Aggleton (2003), Helman (2000) and Leininger (2001) argue that lay beliefs about health are no less important than professional definitions, since they influence the ways in which people perceive and respond to health issues and should be given greater prominence for understanding how people of various cultures interpret their ill health and how they respond to it.

2.2.1 Professional and lay perspectives of health

To explain these different perspectives of health, Helman (2000) and Kleinman (1984) use the terms *disease* and *illness*. Even if they come from the same socio-cultural background, medical professional and lay people are claimed to view health differently.

Defined by Kleinman (1984):

Disease refers to a malfunctioning of biological and / or psychological processes, while the term *Illness* refers to the psychological experience and meaning of perceived disease. Illness includes secondary personal and social responses to a primary malfunctioning (disease) in the individual's physiological or psychological status (or both). Illness involves processes of attention, perception, affective response, cognition, and valuation directed at the disease and its manifestations (i.e., symptoms, role impairment, etc.). But also included in the idea of illness are communication and interpersonal interaction, particularly within the context of the family and social network. Viewed from this perspective, illness is the shaping of disease into behavior and experience. It is created by personal, social, and cultural reactions to disease (Kleinman, 1984, p.72)

While Kleinman (1984) sees disease as malfunctioning of biological and psychological processes of an individual, illness is seen as a coping function to disease by the individual or the people around the victim. "Illness contains responses to disease which attempts to provide it with meaningful form and explanation as well as control" says (Kleinman, 1984, p.72)

Disease - The professional perspective. According to Helman (2000) the medical profession is influenced by its own values, theories of disease, rules of behavior and organization. It is assumed that under the process of medical professional education, gradually a culture is acquired of how ill health should be viewed, and this perspective is said to last throughout their professional life. Western medicine is based on scientific reasoning, where all assumptions and hypotheses should be capable of being tested and verified under objective, measurable, and controlled conditions. It is then only that phenomena related to health and sickness are said to be real. After being observed and often quantified only then they become clinical facts for the cause to be discovered. The assumption being that all facts have a cause and that the job of the medical professional then is to discover logically the chain of events that influenced this particular fact. For each measurement there is claimed to be a numerical reference range where the normal value within which the individual is said to be normal and healthy whilst above or below this range is abnormal and then the individual is said to have a presence of a disease. Therefore disease is seen as deviation from these normal values together with abnormalities in the structure and function of the body. Helman (2000) therefore says that the medical definition of ill health is largely based on "objectively demonstrable physical changes in the body structure or function that can be quantified by reference to normal physiological measurements" (Helman, 2000, p.80). This view excludes the social, cultural and physiological dimensions of ill health and the context in which it appears, which determine the meaning of the disease for the individual patients and those around them (Helman,

2000; Kleinman, 1984). Western medicine is said to focus mainly or more on the physical dimensions of illness. Important factors such as personality, religious belief, culture and socio-economic status of the patients are often excluded in diagnosing and prescribing the treatment at times of illness (Helman, 2000).

Illness - The lay perspective. Illness is said to be a subjective response of a person to being un-well (Helman, 2000; Kleinman, 1984). How he or she and those around them are supposed to interpret the origin and significance of the event that affects their behavior and relationship with others, and the various steps taken by the individual to correct the situation. Illness not only includes the individual's experience of ill health, but includes also the meaning he or she gives to that experience. Helman (2000) claims that the meanings given to the symptoms and their emotional responses to these are influenced by the peoples own background, personality, cultural, social and economic context in which the symptoms appear. Illness often share psychological, moral and social dimensions associated with other forms of misfortunes, within a particular culture (Helman, 2000; Kleinman, 1984). Helman (2000) therefore claims that illness is a more diffused concept than disease and should be given greater importance for understanding how people interpret their ill health and how they respond to it.

2.2.2 Lay theories of illness causation

There are four lay theories of illness causation presented by Helman (2000) to show how lay people associate their beliefs to ill health.

1. Within the individual world
2. In the natural world
3. In the social world
4. In the supernatural world.

The individual world. Malfunctions within the body are the focus of lay theories that locate the origin of ill health within the individual. Here most of the responsibility is placed on the people themselves. The belief common in the western world where at times encouraged by respective governments health education campaigns, ill health could be blamed on ones diet, dress, hygiene, lifestyle, relationships, sexual behaviour, smoking and drinking habits and physical exercise. Ill health is assumed to be related to such as carelessness and the person affected should feel responsible for causing it. The extent to which people believed their health was determined by their own actions as opposed to luck, chance or powerful external forces can also be related to socioeconomic factors such

as education and home ownerships. People with better education and socioeconomic conditions were shown to take more responsibility for their ill health than others. Helman (2000) claims that explanations for ill health that are individually centred are important in determining whether people take responsibility for their health, or whether they see the origin or curing of ill health as lying largely outside their own control.

The natural world. This is supposed to include factors in the natural environment both living and non living which are assumed to cause ill health. Climatic conditions, such as excess cold, heat, wind rain, snow, dampness and natural disasters are said to belong to this group. Where astrology is practiced it is believed that the sun, moon and other planetary bodies could influence health. Astrological birth signs are also perceived as a form of hereditary proneness to good health or illness. Other natural factors are said to include traumas inflicted by animals or birds and infections caused by germs or micro-organisms. Some other causes of ill health were environmental irritants. Allergens such as pollens, poisons, food additives, smoke, and fumes were said to be the commonly attributed causes of illness in the USA.

The Social world. Among some societies it is a common feature that people blame the others for one's ill health. Witchcraft, sorcery and the evil eye are some of the most common forms attributed to the cause of ill health and other forms of misfortune.

Witchcraft: Certain people usually women were supposed to have mystical powers that could harm others. Accusations of causing illness were more common during the time of social changes and conflict. Factions within society competed with each other then accused each other for their downfalls and misfortunes by practising witchcraft. During these events the identification of the witch causing these misfortunes were attempted to be exposed and the negative effects exorcised.

Sorcery is supposed to be different from witchcraft and is common mainly in non western societies. In sorcery the sorcerer is said to exert his or her power consciously, usually with purpose and reasons of jealousy and hatred. He or she is supposed to cause illness by means of certain spells, potions or rituals. Sorcery is supposed to be often practiced in the social world of family, friends, or neighbours and often based on jealousy. Sorcery beliefs are said to occur often in groups whose lives are influenced by poverty, insecurity, danger and with those with feelings of inadequacy and powerlessness.

The belief that the evil eye causes illness is supposed to exist both in the industrialised and non industrialised world. In the Middle East, the belief exists amongst all communities, immaterial of religious backgrounds. By those who practice this belief it is assumed that it

can cause several illnesses. The possessor of the evil eye is said to harm its offer unintentionally and generally said to be unaware of their powers and unable to control them. Usually the person who bears the evil eye could be a stranger or a local person who may differ in social activity, attitude, appearance and behaviour from the local norm. Specially if a person stares rather than speaks is assumed to be quite harmful. Tourist or foreign health workers are said to be often accused of possessing evil eyes and thought to be a source of illness especially if they had been seen staring at a child or giving it compliments and praise just before it fell ill.

In western societies lay notions of stress are often said to play a similar role as to blaming ones ill health on other people. For example, like blaming ones ill health on spouses, children, family, friends and workmates. Being infected with a disease and falling ill too is said sometimes to be blamed on other people. Like for instance “He gave me his cold’ or ‘I caught his germ” (Helman, 2000, p.94).

The supernatural world. The cause of illness here is attributed to the direct influence of supernatural powers such as gods, spirits, or ancestral shades.

In a study of low income African Americans by Snow in Helman (2000) illness had been often ascribed as a ‘reminder’ of God for bad behaviour, for example such as not going to church regularly, not reciting one’s prayers or being unthankful for one’s God’s daily blessings. Due to this, treatment by home based remedies or a physician was considered inadequate. The accepted cure for this type of belief was considered the acknowledgement of sin, showing sorrow and repentance for having committed it and a promise to improve one’s behaviour mainly through prayer.

Some times illness is considered to be brought about by malevolent spirits. Lewis in Helman (2000) describes that in some African communities’ disease bearing spirits were said to cause illness unexpectedly, bringing about different symptoms to its victims. These spirits are said to reveal their identity by the symptoms they cause and the victims could only be cured by driving these spirits out of the body.

Another type of spirit described is when the victim is supposed to have been invaded and made ill by the spirit of their ancestors whom they have displeased. The offence could be immoral behaviour and diagnosis is said to take place in a divinatory manner where illness is seen as punishment for these transgressions, and the moral values of the group are reaffirmed.

2.2.3 The three systems of health care

Klienman (1984) and Helman (2000) quite similarly to Leininger (2001) distinguish between three sectors or systems of health care to which people resort to at times of illness and where care and healing could take place. They constitute; the popular, folk and professional health care systems. Each system is said to have its own explanations and treatment of ill health.

The popular system. This sector includes the lay and non professional circle of society. It is here that ill health is first recognised and care activities initiated. These activities include all curing methods that people use without having to pay or consult either folk healers or medical personnel for treatment. The popular sector generally includes a set of beliefs about health maintenance. These beliefs are usually a culture specific series of guidelines in order to prevent ill health in one self and others. These beliefs and guide lines may often include healthy ways of how to eat, drink, sleep, dress, work, pray and usually conduct ones life. In some societies illness is said to be prevented by the use of charms, amulets and religious medals in order to attract good luck and good health. Health care in this sector takes place between people already connected to each other by kinship, friendship or neighbourhood or membership of work or religious organisations. In these types of ties both patient and healers are said to share similar assumptions about health and illness. The sectors include a series of informal and unpaid healing relationships and of variable duration and occur within the sufferer's own social network especially the family. These therapeutic encounters occur without any fixed rules and at a later date that the roles may be reversed with the days patient becoming tomorrow's healer.

The folk system. This sector is large, especially in developing countries where certain individuals specialize in forms of healing that are either sacred or secular or some times a combination of the two forms. The healers are not a part of the official medical system and occupy an intermediate position between the popular and professional sectors. They function for e.g. as bone setters, midwives, tooth extractors, herbalist and spiritual healers. Most healers of the folk sector share the basic cultural values and world view of the communities in which they exist, which include beliefs about the origin, significance and methods of treatment of illness. Amongst people where ill health and other forms of misfortune are supposed to be blamed on social causes such as witchcraft, sorcery and or evil eye or on supernatural powers such as Gods, spirits, ancestral spirits or fate, sacred folk healers are supposed to be common. The healers are supposed to practice a holistic approach dealing with all aspects of the patient's life consisting of relationships with other

people, with the natural environment and with supernatural forces, as well as any physical or emotional symptoms. In many non industrial societies all these aspects of life are said to make up the definition of health, which is seen as a balance between people and their social and supernatural environments. A disturbance of any of these environments by immoral behaviour, conflicts within the family or failure to observe religious practice may result in physical symptoms or emotional distress and calls for the services of a folk healer. For people who make use of folk healing it is said to offer several advantages over western scientific medicines. One such advantage is supposed to be the involvement of the family in diagnosis and treatment.

The professional system. This sector is made up of the organised, legally sanctioned healing professions exhibited by modern western scientific medicines. It includes medical specialists of various types as well as the recognised paramedical professions such as nurses, midwives and physiotherapist. In most countries it is scientific medicine that is the basis of the professional sector, but as Helman (2000) points out, traditional medical systems may also become professionalized to some extent with examples such as Ayurvedic and Unani medical colleges in India which are supposed to receive governmental funding. Western scientific medicine provides only a small proportion of the needed health care in most countries and most health care practices are claimed to take place in the popular and folk sectors.

2.3 Trans-Cultural Nursing and Culture Care Theory

In the mid-1950 whilst working as a child psychiatric mental health nurse with disturbed children of different cultural backgrounds that Leininger's interest had focused on the importance of culture in care (Leininger 1995, 2001). She had experienced what she describes as a cultural shock and says: "I experienced cultural shock and felt helpless to assist children who so clearly expressed different cultural patterns and ways they wanted care" (Leininger, 2001, p.14). Her conclusion was that it was a lack of knowledge of the children's cultures that deprived them of proper nursing care. This factor as well as curiosity had led her to a doctorate in anthropology and later the development of trans-cultural nursing and the theory of Culture Care Diversity and Universality which according to Leininger (2001) is known to be the first nursing theory that focused systematically in explaining care given from a trans-cultural perspective. The Sunrise model or Enabler (figure.1) was also developed by Leininger to depict and aid in the application of her theory (George, 1995; Leininger and McFarland, 2002, 2006).

2.3.1 Trans-cultural nursing

The term “trans-cultural nursing” is used by Leininger (1995, 2001) as a discipline of study and practice focused on comparative culture care differences and similarities among and between cultures in order to assist people to maintain or stay healthy or face handicaps and even death.

Whilst Leininger (1995) defines nursing as;

Learned humanistic and scientific profession and discipline focused on human care phenomena and activities in order to assist, support, facilitate or enable individuals in order to maintain or regain their well-being (or health) in culturally meaningful and beneficial ways or to help people face handicaps (Leininger, 1995, p.105)

Trans-cultural nursing is defined by Leininger (1995) as;

A formal area of study and practice in nursing focused upon comparative holistic cultural care, health and illness patterns of individual groups with respect to differences and similarities in cultural values, beliefs, and practices with the goal to provide culturally congruent, sensitive, and competent nursing care to people of diverse cultures (Leininger, 1995, p.4)

In trans-cultural nursing, Leininger (2001) stresses the importance of knowledge gained from direct experience or directly from those who have experienced the phenomenon under study. Such knowledge is known as emic, or people centred. The theorist stresses that emically derived care knowledge is essential for proper nursing practice. Emic or people centred derived care knowledge is contrasted with etic knowledge, which describes the professional perspective.

2.3.2 Culture Care Theory / Theory of Culture Care Diversity and Universality

Leininger had taken the idea of culture from anthropology and the concept of care from nursing and put them together in developing her trans-cultural nursing theory. Based on this foundation, nursing care is derived and developed from a cultural context in which care is to be provided (Leininger, 1995, 2001). Her theory is built on the premises that the people of each culture not only can know and define the ways in which they experience and perceive their nursing care world but also can relate these experiences and perceptions to their general health values, beliefs and practices. By using the culture care theory, the theorist says a nurse researcher can discover what constitutes health with its meanings and symbols, and with ways cultures know, transmit and practice health care including intergenerational practices. The theory directs nurses to discover what is universal (common) and what is diverse (different) about these values, beliefs and practices of the culture being studied. From the knowledge gathered by its application, the theory predicts

three action or decision modes for providing culturally congruent nursing care to people which is the ultimate goal of the theory; 1. Culture care preservation and –or maintenance, 2. Culture care accommodation and-or negotiation and 3. Culture care re-patterning and-or restructuring. These decision modes are defined in section 2.3.3 of this paper.

Assumptive Premises and definitions. Leininger (1995, 2001) has formulated several assumptive premises and definitions in her theory which are meant to be used as guides to systematically study the theory and to discover prevailing culture care and health phenomena. Definitions of culture, nursing and trans-cultural nursing have been presented earlier in this chapter and will not be repeated, the definitions and some of the assumptions that support her predictions in the theory for the concepts of health, care, culture care, cultural care diversity, and cultural care universality are presented below, whilst relevant concepts used in the Sunrise model is defined during the presentation of the model.

Health according to Leininger (2001) is “a state of well-being that is culturally defined, valued, and practiced and which reflects the ability of individuals (or groups) to perform their daily role activities culturally expressed, beneficial, and in patterned life-ways” (Leininger, 2001, p.48). The concept of health is studied in relation to care by Leininger (2001). As the modes of care values, beliefs and practices exhibited by various cultures are seen as influencing the holistic health and wellbeing of people, these care values, beliefs and practices are predicted to be powerful explanatory means to discover and understand health as well as to explain or predict illness conditions. Leininger assumes that if one understands the meanings and forms of care, one can predict the health and well being of people. Health is viewed as being universal across cultures but defined within each culture in a manner that reflects the beliefs, values and practices of that particular culture. Thus health is assumed to be both universal and diverse across cultures. One of the theorists many assumptions in the definition of health as well is that all cultures have generic (lay, folk or indigenous) and professional health care beliefs and practices that people relate their health to and seek remedies and treatment from during times of illness. Health is also assumed to be an important concept in trans-cultural nursing according to Leininger (2001) because of the emphasis on the need for nurses to have knowledge that is specific to the culture in which nursing is being practiced.

Care is defined as; “abstract and concrete phenomena related to assisting, supporting, or enabling experiences or behaviours toward or for others with evident or anticipated needs to ameliorate or improve a human condition or life-way” (Leininger, 2001, p.46) and the

related assumption is that care is the essence of nursing and a distinct, dominant, central and unifying focus.

Caring is defined as; “actions and activities directed towards assisting, supporting, or enabling another individual or group with evident or anticipated needs to ameliorate or improve a human condition or life-way or to face death” (Leininger, 2001, p.46). The related assumption is that caring is essential for well-being, health, healing, growth, survival and to face handicaps or death. Caring is also assumed by Leininger (2001) as essential to curing and healing, and she assumes that there can be no curing without caring.

Culture Care is defined as;

the subjectively and objectively learned and transmitted values, beliefs and patterned life-ways that assist, support, facilitate, or enable another individual or group to maintain their wellbeing, health, improve their human condition and life-ways or to deal with illness , handicaps or death (Leininger, 2001, p.47).

The related assumption is that cultural care is “the broadest holistic means to know, explain, interpret and predict nursing care phenomena to guide nursing care practices” (Leininger, 2001, p.44).

Cultural care diversity is defined as; “the variabilities and/or differences in meanings, patterns values, life-ways or symbols of care within or between collectives that are related to assistive supportive, or enabling human care expressions” (Leininger, 1995, p.105)

Cultural care universality is defined as; “the common, similar, or dominant care meanings, patterns, values, life-ways or symbols that are the manifest among many cultures and reflect assistive, supportive, facilitative, or enabling ways to help people” (Leininger, 1995, p. 105).

2.3.3 The Sunrise Model or Enabler to discover Culture Care

The theory of Culture Care Diversity and Universality is depicted with the aid of the Sunrise model or enabler (figure.1) (Leininger 1995, figure 3-1, p.108) and (Leininger and McFarland 2006, figure 1-1, p.25). The model provides nurses with a cognitive map or visual image to aid in conceptualising the components of the theory (George, 1995; Leininger and McFarland, 2002, 2006). The model is presented in the form of a rising sun which is meant to symbolise the expected purpose of the theory. That is discovering new knowledge that could brighten the knowledge of nursing of other cultures. It aids the understanding of the different cultural forces that influence care which in turn influences the health and well being of individuals, families groups, institutions, and communities and different health care systems.

The Sunrise model or enabler consists of four levels. The function of the first three levels is to generate knowledge for the fourth level that guides the three theoretical decision modes of nursing care in providing finally what Leininger (1995, 2001) calls culture congruent nursing care which is the ultimate goal of the theory.

Level 1 and 2 consists of worldview, cultural and social structure dimensions, environmental context, language and ethno-history. From these factors Leininger (2001) assumes that knowledge of what is universal or common and what is diverse or different about health and care values, beliefs, expressions and practices could be derived at that effect holistic health and wellbeing of the particular culture being studied. The theorist assumes that the knowledge derived from these factors is essential to guide nursing decisions and actions in providing cultural congruent care.

Worldview is said to be the way in which people look at the world or universe and form a “picture or value stance” (Leininger, 2001, p.47) about the world and their lives.

Cultural and social structure dimensions are defined as;

the dynamic patterns and features of interrelated structural and organisational factors of particular culture (subculture or society) which includes religious, kinship (social), political (and legal), economic, educational, technologic and cultural values, ethno-historical factors and how these factors may be interrelated and function to influence human behaviour in different environmental contexts (Leininger, 2001, p. 47).

Cultural and Social Structure Dimensions are said to be a major guide and feature of the theory, providing broad, comprehensive, and in depth knowledge of factors that are said to influence holistic health and care expressions, beliefs and practices.

Environmental context is defined as “the totality of an event, situation, or particular experience that gives meaning to human expressions, interpretations, and social interactions in particular physical, ecological, socio-political and/or cultural settings” (Leininger, 2001, p.48).

Ethno-history is defined as “those past facts, events, instances, experiences of individuals, groups, cultures, and institutions that are primarily people-centred (ethno) and which describe, explain, and interpret human life-ways within particular contexts and over short or long periods of time” (Leininger, 2001, p.48).

Ethno-history is said to be another guide to attain culturally congruent care where past and present events and conditions within the historical context of cultures and caring modalities are considered as important data. Health and care knowledge obtained from level 1 and 2

about either individuals, families, groups, communities, and institutions flows into the diverse health care systems located in the lower half (level 3) of the model .

Level 3 Here the specifics of each diverse health care system as explained earlier in the chapter, consisting of the generic (lay, folk or indigenous) and professional care systems including nursing are identified.

A generic (folk or lay) care system which is emic (insiders view) is defined by Leininger (2001) as;

those largely emically learned and transmitted indigenous (or traditional) folk (home-based) cultural knowledge and skills used to provide assistive, supportive, enabling or facilitative acts toward or for another individual or group with evident anticipated needs, to ameliorate or improve a human life-way, health condition, or to deal with handicaps and death situations (Leininger, 2001, p. 48).

Professional care systems which is etic (outsiders view including nursing) is defined by Leininger (2001) as “formally taught, learned and transmitted professional care, health, illness, wellness and related knowledge and practice skills that prevail in professional institutions usually with multidisciplinary personnel to serve consumers” (Leininger, 2001, p.48).

Leininger (1995) postulates that knowledge of generic care practices could revolutionize nursing and health care practices if combined properly with professional care practices. It is assumed that clients will show signs of faster recovery from illness, experience less cultural stress and conflict with the professional services if the systems are skilfully integrated. The opposite is expected if the benefits of the systems are not well integrated resulting in the absence of culturally congruent care.

Level 4, at this level the knowledge gained from the three previous levels provide the base for three modes of nursing care decisions and actions in providing culturally congruent nursing care. All of which require the co participation of the nurse and clients. The three modes of nursing care decisions and actions as mentioned earlier are “cultural care preservation and/or maintenance, cultural care accommodation and/or negotiation and cultural care restructuring and/or re-patterning” (Leininger, 1995, p.103)

Culture care preservation and -or maintenance refers to “those assistive, supporting, facilitative or enabling professional actions and decisions that help people of a particular culture to retain and /preserve relevant care values so they can maintain their wellbeing, recover from illness or face handicaps and /or death” (Leininger, 1995, p.106).

Culture care accommodation and-or negotiation refers to “those assistive, supporting, facilitating or enabling creative professional actions and decisions that help people of a designated culture adapt to or negotiate with others for beneficial health outcome with professional care providers” (Leininger 1995 p.106).

Culture care re patterning and-or restructuring refers to;

those assistive, supporting, facilitating or enabling creative professional actions and decisions that help clients reorder, change or greatly modify their life-ways for new, different and beneficial health care patterns while respecting clients’ cultural values and beliefs and providing a life-way more beneficial or healthier than before the changes were co-established with the clients (Leininger 1995 p.106).

Leininger (2001) explains that re-patterning requires the creative use of an extensive knowledge of the client’s life-ways while using both generic and professional knowledge.

Culturally congruent (nursing) care is referred to as:

those cognitive based assistive, supportive, facilitative or enabling acts or decisions that are tailor made to fit with individual, group or institutional cultural values, beliefs and life-ways in order to provide or support meaningful, beneficial and satisfying health care or well-being services (Leininger 1995 p.106).

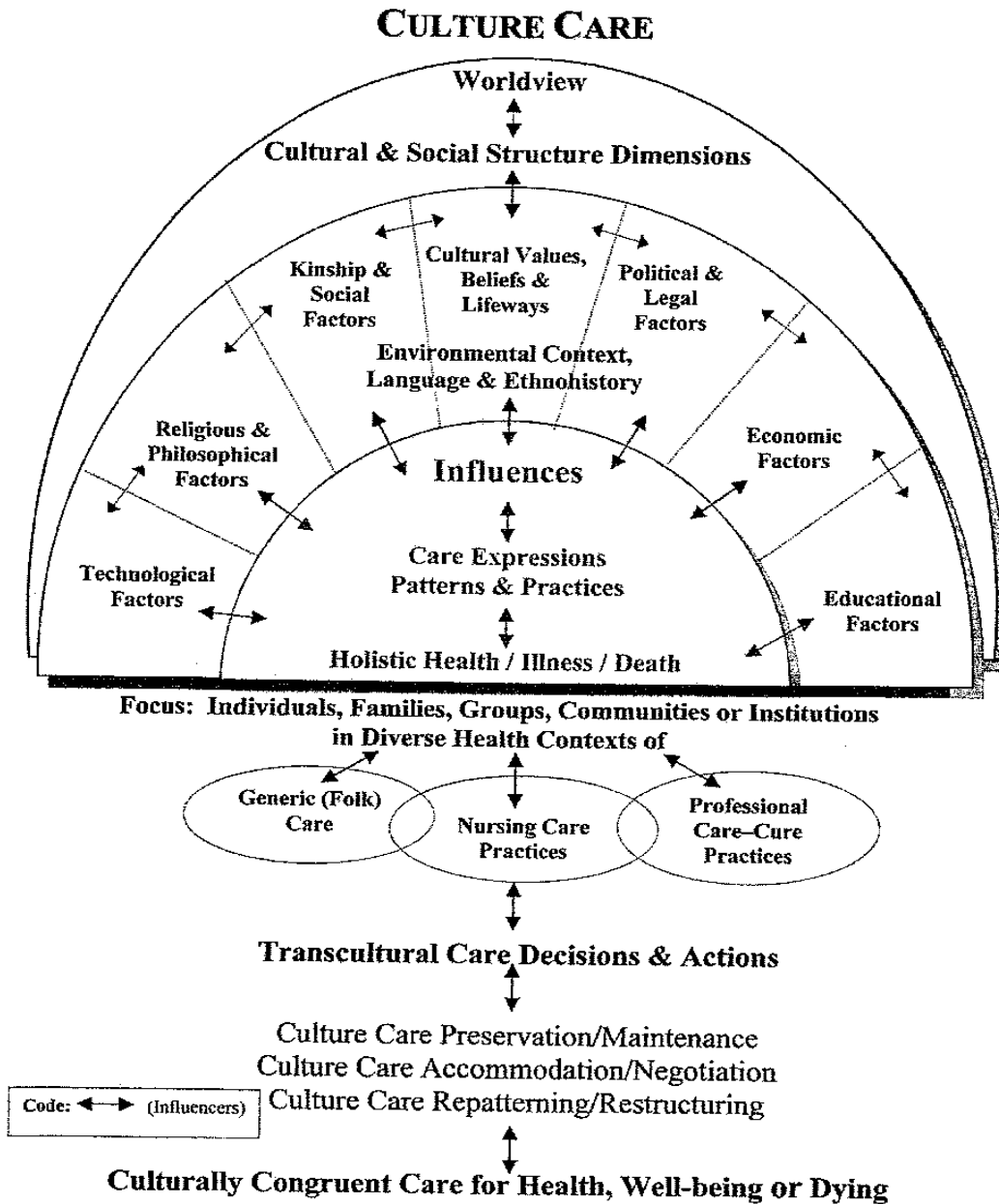
A related assumption is that nursing, as a trans-cultural care discipline and profession, has a central purpose to serve people in all areas of the world, when culturally based nursing care is beneficial and healthy it contributes to the well-being of the client whether individuals, groups, families, communities, or institutions-as they function within the context of their environments. It is also assumed that nursing care will be culturally congruent or beneficial only when the clients are known by the nurse and the clients’ patterns, expression, and cultural values are used in appropriate and meaningful ways by the nurse with the clients. Finally it also assumed that if clients receive nursing care that is not at least reasonably culturally congruent, the clients will demonstrate signs of stress, non compliance, cultural conflicts, and/or ethical or moral concerns.

Leininger (1995) mentions that the researcher could start with the Sunrise model by studying the world view, social structure dimensions, and ethno-history of the people concerned or may start with the generic (folk) and professional care part of the model to discover ideas related to the domain of inquiry but later could reflect on social structure dimensions and other factors. Immaterial if one focuses in the middle, top or bottom of the model, she says the researcher is free to explore ideas in any area that influences care and health. The cultural and social structure dimensions are a major construct given prominence in this study.

Figure1 The Sunrise model or enabler

From Culture Care Diversity and Universality: A Worldwide Nursing Theory (Leininger and McFarland 2006, figure 1-1, p.25)

Leininger's Sunrise Enabler to Discover Culture Care



Leininger's Sunrise Enabler to Discover Culture Care

3.0. SRI LANKA: A GEO HISTORICAL GLIMPSE, IT'S ELDERLY, HEALTH SERVICES, SYSTEMS OF HEALTH CARE AND CARE FOR THE ELDERLY. THE MIGRATION OF SRI- LANKANS TO NORWAY AND ELDERLY IMMIGRANTS IN NORWAY

3.1. Geo Historical Glimpse of Sri Lanka

3.1.1 Environment

The Island of Sri Lanka which is approximately 65610 square kilometers is situated in South Asia and lies to the Southeast of India in the Indian Ocean. It is a flat tropical country, except for a central mountainous region. These ranges of mountains divide the Island into two distinct regions and also block the monsoon winds which are responsible for the tropical climate. The southwest receives abundant rainfall, and the remainder of the island is drier. Large tea plantations cover the southern mountain slopes, and other major crops are rice, rubber, coconuts and cocoa. Sri Lanka also boasts of tropical rain forest with a variety of plant and Animal species (The world Guide, 2001/2002).

3.1.2 History

According to the world Guide (2001/2002) Sri Lanka once known as Ceylon under British rule was populated by the Vedda or local aborigines in ancient times, after which it was successively invaded by the Sinhalese, Tamils & Indo-Europeans who laid the foundation of an advanced civilization. When the Portuguese arrived in 1505 the Island was divided into seven autonomous local societies. 150 years later the Dutch had expelled the Portuguese from their coastal trading post and ruled most of the Island. Finally the last foreign rulers were the British who made the island a colony by expelling the Dutch in 1796. However, it had been only in 1815 that the British had managed to suppress all the local governments who had fought hard to remain autonomous. In 1948, Sri Lanka gained her Independence and become a member of the British Commonwealth of countries. In 1972 Ceylon was declared a republic and renamed Sri Lanka. According to Spittel (2001) Sri Lanka's oldest name had been Lanka and still referred to as Lanka by the Sinhalese. At present the country is divided administratively into eight provinces, 25 districts and over 300 Divisional secretariat areas (Abeykoon, 2002). Sri Lanka has a parliamentary system of government where the elected parliament is responsible for legislative functions, and the cabinet of ministers, presided over by the Executive President, vested with executive powers. The provinces have their own provincial councils, headed by a governor and elected representatives (Abeykoon, 2002).

3.1.3 Its People

Sri Lanka is a multicultural society and had a population of 18.924 million in 2000, consisting of Sinhalese 74 %, Tamils 18 %, Moors 7 %, Burgher, Malay, Vedda and others 1 % (Abeykoon, 2002). The percentage of major Religions are; 69% Buddhist, 15% Hindu, 8% Christian (Protestant and Roman Catholic), 7% Muslim; and 1% other religions (The world guide, 2000/2001).

Veddas. The Sri Lankan aboriginal people are known as the Veddas (Spittel, 2001). Spittel (2001) says that the Veddas are probably the descendants of the people who lived in the island long before the arrival of the Sinhalese or Tamil settlers from India. According to Spittel (2001) scattered in the arid forest of central Sri Lanka this destitute of nomad people's ethnic origins derive from the very dawn of human evolution and lives to this day very much represents the primitive hunter. Vedda is written in Sanskrit as Vyadha which means "one who pierces (a hunter)" (Spittel, 2001, p.69). However, the Veddas are claimed to be a fast disappearing race. They are disappearing due to Vedda women and men marrying Sinhalese or Tamil villagers as well as due to modern development where highways and dams destroy their habitats. Therefore Spittel (2001) expresses doubts as to whether there are really any pure Veddas left any longer in Sri Lanka. Many jungle communities called Vedda are said to be only in name. In clothing, in habits, and as in appearance Veddas are said to resemble the Sinhalese or Tamil people.

Sinhalese. According to UDI (1991/1992) the Sinhalese are the biggest ethnic group in the country and could be divided into two main groups, namely the "Up Country Sinhalese" and the "Lower Country Sinhalese". Both these groups are mainly Theravada (Hinayana) Buddhist, with a few Christians among them. The majority of Christians among the Sinhalese are found amongst the Low Country Sinhalese who live in the coastal areas of the South and Western regions of the country (Malone, 1975). The language Sinhalese solely spoken by the Sinhalese of Sri Lanka is an Indo-European language associated with other North Indian languages UDI (1991/1992).

Tamils. According to the UDI (1991/1992) there are two main groups of Tamils, namely the Sri Lankan or Ceylon Tamils who constitute to the majority of Tamils living in the country and the Indian Tamils in lesser numbers. The biggest settlements of Sri Lankan Tamils are found in the Northern and Eastern parts of the country. The Sri Lankan Tamils claim to have inhabited the island thousands of years ago almost during the same time as the Sinhalese, whilst the Indian Tamils were brought over by the British during their period of colonization (1796-1948). The settlements of these Tamils are found in the central hills

of the country. The majority of Tamils are Hindus. The Tamils speak Tamil of different dialects which along with Sinhalese is now recognized as an official language (Orions Store Verdens Atlas, 1999). Tamil is a Dravidian language associated with the languages of the Southern parts of India (UDI, 1991/1992).

Muslims. Sri Lankan Muslims can be categorized into two distinct sub groups, the Moors and the Malays. Moor is the name that had been given to them by the Portuguese who had used the word Moros to identify Arabs in general. The Moors are claimed to be descendants of Arab traders from Hashemite origins, Yemeni traders and of the Berbers of Morocco and North Africa, who had been visiting and trading with the Island from ancient times. The settlements of these Muslims are mainly in the Eastern and South Western belts of Sri Lanka with a few other smaller pockets of settlements in other areas as well. They speak a form of Tamil with a strong influence of Arabic (UDI, 1991/1992).

According to Hussainmiya (2001), the Malays are said to be a group of Muslims who had originated from Java and the Malaysian peninsula. The definite arrival of the Malays to Sri Lanka had first taken place in the 13th Century when a Malay king had invaded Northern Sri Lanka in AD 1247. The second and third wave of Malay settlements had taken place during the Dutch and British periods.

Burgers. According to UDI (1991/1992) the Burgers or Eurasians are a group of people with European descent of the colonial rulers. When the Portuguese arrived in Sri Lanka in 1505 they brought soldiers and other supporting staff. Those who settled down got married to local women and a new ethnic group was born. Soon, the Dutch and English followed suite. The descendants of the union between the colonizers and the locals came to be known as Burghers. The majority of Burghers are either of Catholic or Christian denominations.

Other minority groups. Other minority groups mentioned in [www.Virtual Library](http://www.VirtualLibrary.com) – Sri Lanka are; Colombo Chetties, Ceylon Jews, Rodi, Gypsies and Sri Lankan Blacks or Kaffirs.

Languages. In addition to the Sinhalese and Tamil languages, English is also a main language that is spoken in Sri Lanka. Along with the Burger community certain societies of the Sinhalese, Tamils and other ethnic groups in the major cities speak the English language as their mother tongue (UDI, 1991/1992).

Literacy rate. The literacy rate was 94 % male and 87% female in 1995 (The world guide, 2001/2002).

3.1.4 The conflict

The world guide (2001/2002) mentions that although the years immediately following the end of colonial rule were largely peaceful, throughout most of the island's history there seemed to have been tensions between the majority Sinhalese community and the Tamil community. According to De Vries (2001) the conflict escalated when the British unified the Sinhalese low country and the Tamil areas in the North and the East of the island into one state during their time of rule. However, the BBC (2006) claims that the origins of the current conflict go back to the island's independence from Britain in 1948. Since gaining independence the Tamils strived for autonomy, especially when the Tamil language had been abolished as an official language in 1956 and Sinhalese was made the official language. Hence bitterness over alleged discrimination was the reason given by the Tamil Tiger leader Prabhakaran, as the motivating factor behind his decision to form the Tamil New Tigers militia in 1972. In 1976, they had changed their name to the Liberation Tigers of Tamil Eelam (LTTE) more commonly known as the Tamil Tigers (BBC, 2006). The cause of "Eelam" - a Tamil homeland in the northern and eastern parts of the country was invoked to justify countless suicide bombings by the Tigers on civilian and military targets in the rest of the country according to the BBC (2006). One of the first such attacks had been ordered by Prabhakaran in 1983 where Tamil Tigers attacked an army patrol in the north of Sri Lanka. The attack on the army patrol led to anti-Tamil riots of 1983 in which an estimated 600 people were killed and thousands displaced. From that time onwards the conflict followed a similar pattern (BBC, 2006). For over 25 years the country witnessed a combination of Tamil Tiger suicide attacks and military retaliations. Various international efforts including Norway, to negotiate a peaceful settlement ended up in failure. As per 2006 the civil war had killed about 64,000 people (troops, Tamil Tiger rebels and Tamil, Sinhalese and Muslim civilians), displaced one million people and held back the island's growth and economic development (BBC, 2006). According to Orjuela and Sriskandarajah (2006) the conflict had displaced more than a million Tamils alone internally in Sri Lanka and 800 000 are claimed to be living in exile. Approximately 10 000 Tamils are said to be living in Norway.

3.2. Characteristics of the elderly in Sri Lanka, health services, systems of health care and long term care for the elderly

3.2.1 Old age Defined

There are many definitions of the old, elderly and aged, however, one of the most accepted definitions of old age is its chronological definition as defined by the World Health Organisation (WHO). Chronologically the (WHO) defines elderly to be those between the age of 65-79, the oldest old to be those above 80 and those over 90 as very old (Laake, 2003). This is meant to be a standard definition that defines old age in the developed and developing worlds. However, this chronological definition of elderly or aged is challenged as it is claimed that for many men and women in developing countries some are categorised as old in their forties and fifties (WHO, 2001). Chronic illnesses and disabilities, improper health care, lives lived in poverty and life-course events are considered to be some of the contributing factors. Therefore some definitions define old or elderly to be rather an individual, culture, country and gender specific term (WHO, 2001). While one is considered to be old in Norway, when one has the right to receive a state pension on completing 67 years of age (Hanssen, 1998), Siddhisena (2005) says that age 60 and above is considered the chronological demarcation age in identifying the elderly population in Sri Lanka, since the most common mandatory retirement age in the public and private sector falls between 55 and 60 respectively. However, it is also claimed that in certain sectors people continue to work as long as they are physically fit even though long past 60 years of age in Sri Lanka (Siddhisena, 2005). In slight contrast to Siddhisena (2005), Martin (1990) mentions 65 years as the age of demarcation in South Asia including Sri Lanka since many international agencies had used this age. Some of the smaller studies cited in Martins paper define old age beginning even as early as 50. Health, sex, labour force participation, and socioeconomic status is also claimed to determine age in South Asia including Sri Lanka according to Martin (1990). In Autonomous institutions such as universities in Sri Lanka academics are allowed to continue up to age 65, and even beyond this age limit if they work actively in private and NGO services. Thus Siddhisena (2005) point out that it is complicated to rationalize a single chronological age for commencement of aging in Sri Lanka even though 60 and above is considered the demarcation age. Giving consideration to the above as well as based on studies (Moen 1993, 2002) done in Norway on other South Asian immigrant groups, an age limit of 50 years and older were set for the informants of this study. Other South Asian immigrants living in Norway considered themselves as being old much earlier than the Norwegian elderly.

3.2.2 Life expectancy, health, family situation and marital status

Amongst South Asian countries Sri Lanka has had the largest fertility decline and achieved the greatest life expectancy (Martins, 1990; Abeykoon, 2002; Siddhisena, 2005). The proportion of those over both 60 and 70 years of age in Sri Lanka is claimed to be much higher than any other country in the South Asia region (Siddhisena, 2005). In 2000, 1 in 10 people were over 60 years of age in Sri Lanka whilst in Afghanistan and India 1 in 21 and 1 in 13 respectively. The percentage of Sri Lankans over the age of 65 has increased over the last 25 years, and expected to increase further (Abeykoon, 2002). By the year 2025 it is estimated that ten percent of the population will be over 65 years in Sri Lanka. In 1998 the average Life expectancy of a Sri Lankan at birth was 73 years where male averaged 71 years and females averaged 75 years (The World Guide, 2001/2002).

Once a Sri Lankan reaches the age 65, he or she is expected to live at least another ten to fifteen years, and most in fairly good health, although some may suffer from a variety of ailments such as high blood pressure, digestion problems and diseases of the joints and respiratory system (Martins, 1990).

Like most other South Asians the majority of Sri Lankan elderly live with their off spring, however, family interaction and support take place even when the generations are not living together (Martin, 1990). Further, in Martins (1990) study 50.1 % elderly Sri Lankan women over 65 and older were widows where as only 14.4% men were widowed. 44.6% women were still married compared to 78.3 % men. 4.9% women were single and 6.7% men. The divorce rate for women was 0.5% against 0.6% for men.

3.2.3 Health services, beliefs and practices

Both the public and private sectors consisting of western and traditional indigenous systems provide health care in Sri Lanka. The public sector provides comprehensive health care to nearly 60% of the population whilst the private sector provides mainly curative care for an estimated 50% of ambulatory clients, mainly in the urban and suburban areas. 90% of inpatient care is provided by the public sector. Special service units exist for the armed services and the police (Abeykoon, 2002).

Indigenous medicine or folk systems of healing enjoy almost the same legitimacy and popularity of western medicines (Srinivasan, 1995; Abeykoon, 2002). This is supposed to give the people the option to seek medical care of their choice. Srinivasan (1995) notes that in Sri Lanka the government policy strongly encourages traditional ayurvedic medicine and that there are 13 000 Ayurvedic physicians (1 per 1400 population)

compared to India's 380 000 (1 per 2200 population). Sri Lanka also has a ministry of Indigenous medicine and a department of Ayurveda that takes care of its interest (<http://www.ayurveda.gov.lk>).

Western beliefs and practices have been briefly described in chapter two of this paper, thus emphasis is given to indigenous medicine or folk systems of healing practiced in the country.

Ancient folk practices. According to De Zoysa and Palitharatna in (Petitjean, Jami, and Moulin, 1992), living evidence of conditions and practices of ancient times exists yet amongst the rural Vedda communities. The Veddas possess sufficient medical knowledge for their survival needs. For example they have knowledge of medical plants to treat wounds, and use python fat for fractures. Exorcism that is still practiced today and reputed to have great psychosomatic value in appropriate socio-cultural contexts is believed to be probably introduced by them. The authors claim however that there is no evidence of any attempts to build a connected knowledge system out of these curative beliefs and practices. There also exist traditional healing practitioners called Vedamahattayas who practice a version of Ayurveda providing various types of treatment and care to those in need (Abeykoon, 2002). Vedamahattayas exhibit family traditions of specialising in areas such as orthopaedics, nervous disorders, mental disorders, and bodily disease. They visit homes, providing medical intervention and motivate the relatives of patients to take part in activities that are beneficial to the sick person's health. With the westernisation of health care this tradition is supposed to be fast disappearing but yet exists in remote and smaller villages. De Zoysa and Palitharatna in Petitjean et al (1992) state that by the end of the pre-historic period curative medicines and practices were locally found and available, however, it had been probably not until the early historic period (300 BC – 1250 AD) that Indian Ayurvedic, Siddhi and Arabic Unani systems had been introduced and integrated with local regional (Deshiya Chikitsa) practices. Ayurvedic beliefs are claimed to form the major science underlying the practice of indigenous medicine in Sri Lanka.

The Sri Lankan Ayurvedic Tradition. The term Ayurveda is made up of two words: Ayur and Veda. Ayur means life and Veda means science or knowledge. Thus Ayurveda means the "science of life" (Giger and Davidhizar, 2004, p.506).

The Ayurvedic folk system practiced in the Island with its origins in India and Hinduism is considered to be over 3000 years old. The Sri Lankan ayurvedic tradition is a mixture of the Ayurveda and Siddha systems of India, Unani medicine from the Arabs and most importantly the Deshiya Chikitsa, which is the indigenous medicine of Sri Lanka. The Sri

Lankan branch of Ayurveda embraces all living things animate and inanimate and it is divided into three main branches. Nara Ayurveda, dealing with human life and diseases, Sata Ayurveda dealing with animal life and its diseases, and Vriksha Ayurveda dealing with plant life its growth and diseases (<http://www.ayurveda.gov.lk>). Disease and illness among humans in ayurvedic medicine is considered to be psychosomatic (Giger and Davidhizar, 2004). The Sri Lankan ayurvedic doctrine too dictates that disease or illness not only has germ causation but occurs because of an imbalance of the essential body elements effecting body, mind and soul. In ayurvedic medicine there are five natural elements: ether, wind, water, earth, and fire which represent coolness and warmth in the universe. Of these elements wind, water and fire are considered to be the most important and in humans are represented in the form of air (vayu or vata), bile (pitta) and mucus (kapha). Health and well being is believed to be maintained only when there is a balance between these cool or warm primary body elements (air, bile, and mucus). This balance is usually maintained only when there is equilibrium between the individual as a whole and its environment. When the equilibrium is disturbed one or more of the primary elements are claimed to go out of balance resulting in disease or illness. Behavior and life styles, consumption of a wrong diet and environmental conditions are attributed to upset this balance. The aim of treatment is to regain a state of equilibrium between the cool and warm, dry and wet elements. Thus treatment of an eventual imbalance of the elements are usually through the maintenance of favourable environments, diet, hygiene, physiotherapy and exercise, herbal portions and baths and some times divine rituals and yoga. (<http://www.ayurveda.gov.lk>).

Unani. Unani is another popular form of folk medicine believed and practiced by people of Arabic origin besides Ayurveda in Sri Lanka (Abeykoon, 2002).

Similar to Ayurveda, in Unani it is believed that illness is brought about due to the imbalance essential body elements. Treatment is achieved by gaining a state of balance between warm and cold, dry and wet elements. Thus diet and climate play important roles in the process of healing (Hanssen, 1998).

Supernatural, social beliefs and practices. Besides explanations of ill health due to natural causes such as the imbalance of the body elements, Hanssen (1998) states that among Hindu cultures of the Indian subcontinent there are also some people who associate disease and illness to supernatural and social elements such as spirits, the evil eye, the evil mouth, god, magical powers, astrology and bad karma (destiny brought about by actions of

a previous life). Most of these attributions to ill health, its beliefs and practices have also been briefly explained in chapter 2 of this paper.

3.2.4 Long term care for the Elderly

The family. Sri Lankan cultural norms have a tendency of placing the burden of long term care of the sick and the old on the family thus resulting in a weakened state or county based long term care strategy (Martin, 1990; Abeykoon, 2002). Weerasuriya and Jayasinghe (2005) for example point out that older patients seeking treatment in tertiary centres are generally admitted to wards housing patients ranging from 13 to over 65 years and there is no proper state or county based assessment or follow up of these older patients once they are discharged. This had led to inadequate care, recurrent admissions and poor patient satisfaction especially among the lower income groups. The situation is predicted to worsen due to the aging of the population and socio-economic changes occurring in the society (Martin 1990; Siddhisena, 2005). The majority of Sri Lankan elderly live with their children, however the ability and the willingness of families to support the elderly is said to be declining. Large proportions of females who were at home earlier and extended care are now employed. Children and their spouses were engaged in work out of home due to expectations of economic prosperity. Thus it is estimated that Sri Lanka will witness a drastic increase in long term care needs in the future (Martin 1990; Siddhisena, 2005). Even though the willingness and quality of care from the part of the family had declined, the elderly still preferred to live with their off spring (Martin, 1990). Yet, undoubtedly the family in Sri Lanka represents the traditional social institution for the elderly in Sri Lanka notes Siddhisena (2005). The elderly felt that they were more comfortable in their own homes and received physical and emotional assistance from their spouse and children. Weerasuriya and Jayasinghe (2005) note that the elders living with their spouses and children were significantly less depressed and in better health than those who did not.

According to Siddhisena (2005) the care of older parents were considered a moral obligation of the children from ancient times where traditionally the youngest male child in the family inherited the ancestral house and was expected to co-reside with their aging parents receiving voluntary material and moral support of the other siblings. For the elderly who did not have children it was expected that that the closest relatives took care of them providing material and emotional support. In a study conducted by Andrews and Hennink (1992) on the circumstances and contributions of older persons in three Asian countries

including Sri Lanka it was found out that more than 83% of the elderly co-resided with their spouses or children in both urban and rural areas.

Perera (1999) reveals that the cultural value system of taking care of elders at home and in the community is also influenced by the religions practiced in the country. It is claimed that according to Buddhism, Hinduism, Christianity and Islamic norms and practices, the elderly preserves the highest esteem in society bringing showers of blessing and merits to those who take care of them (Perera, 1999). Thus religion plays a vital role in most Sri Lankan societies in maintaining the social values of taking care of the elderly even though religion is losing its impact on some segments of the society according to Perera (1999).

The Ministries of Social Services and Health. According Abeykoon (2002) Parliamentary act No.9, enacted in 2000 provides for the establishment of a National Council for Elders with the principal function of protecting the rights of the elders. The council is headed by the Secretary to the ministry of social services who is legally entrusted with ensuring the welfare of elderly individuals, but the ministry has been accused of not being very efficient in providing long term care to the elderly (Abeykoon, 2002). A recent development however is supposed to involve day care clinics for the elderly operated by medical officers in the field. A few attempts have supposed to have been made by the ministry of health to link up with the social services department at the national level, however these efforts are believed to have been short lived. In the few districts where these day care centres are operative, the elders are said to be provided with food and other needed medical assistance. The Nongovernmental Organisation (NGO) Help Age Sri Lanka is said to be involved in training volunteers for this programme.

Nongovernmental Organisations (NGOs). In Abeykoon's (2002) study many NGOs are also involved at national and provincial levels assisting the Social Service department's community based programmes. There are 155 homes for the elderly which are run by small nongovernmental associations. The government finances only three such homes located in three different districts. One of the few NGOs having a major impact on long term care for the elderly is Help Age Sri Lanka (Abeykoon, 2002). The Organisation is involved in many activities such as providing direct monetary assistance to or for homes for the elderly, eye care services, day care centres, eye glasses, wheel chairs, and walking aids. The institution is also involved in educating school children and medical students about the needs of the elderly. They even help the older people plan their retirement. Help Age's most significant contribution to long term care is in the area of training of personnel in needs assessment, provision of community based services, and gerontological home care.

Help age have assisted in intersect-oral cooperation and income generation for the elderly where the ministries of Social Services and Health services have been the beneficiaries.

Private Services. Many large and small private companies exist in Sri Lanka providing home based nursing care against payment, however due to their high charges, only the rich could afford their services says Abeykoon (2002). The most significant contributor to the home care service in the private sector is that of the off duty government hospital employees says Abeykoon (2002) where attendants, labourers, midwives, and occasionally nurses are involved in providing care at a much affordable rate. These people are generally contacted by the persons needing care directly while being hospitalised or by personal networks like immediate relatives and friends. According to Abeykoon (2002) there also exist a few fee-levying homes for the elderly and disabled. These institutions are said to charge an admission fee as well as a monthly fee depending on the comforts provided.

Income support. Siddhisena (2005) in his studies show that the elderly in Sri Lanka have a serious problem regarding adequate income for later life. The majority of the elderly do not have retirement benefits such as formal pensions or other means of old aged security schemes. Retirement benefits cover only about 50% (pensions to the state employed and lump sum provident funds in the private, corporate sectors and universities) of the elderly population since most employed were in informal activities. Older people who have worked in the private unorganised or informal sector are severely affected by inadequate resources and many depend on their savings and relatives to manage.

3.3 The Migration of Sri Lankans to Norway

Immigrant is a term that is applied to a person who has come into a foreign country for settlement there (Hayward and Sparkes, 1988). With association to Norway, people born abroad by foreign-born parents are defined as immigrants (SSB, 2007). They must also be registered as residents in Norway for at least six months. The term immigrants is said to also include those who have come: as refugees, labour immigrants, students or through family relations with others with or without immigrant backgrounds (SSB, 2007).

In this study the term elderly Sri Lankan immigrant includes guest workers, asylum-seekers, refugees, and those who have arrived through family-reunions and as students. According to the information magazine provided by the Norwegian foreign department (UDI, 1991/1992), the first Sri Lankan immigrant to take up permanent residency in Norway had arrived in 1956. He was a Northern Tamil in descent. Most of the pioneer settlers had close connections to him and arrived in the country mainly as guest workers.

Political, social and personal reasons had contributed for leaving the shores of Sri Lanka. This first group of immigrants opened the way for later arrivals. In 1975 Norway too followed the suite of the rest of Western Europe and closed its borders for guest workers from non-western countries. After the tightened immigration policy, most arrivals were due to family reunion, students to folk high schools and universities. The second wave of Sri Lankan immigrants had arrived in the early 1980s with the stepping up of the ethnic conflict. This second wave of immigrants consisted mainly of either relatives or friends of the earlier immigrants. The numbers continued to grow steadily with the arrival of refugees and political asylum seekers until the early 1990's. In 2005, a total of 11,475 Sri Lankan immigrants within all age groups were living in Norway (SSB, 2004).

3.5 How elderly immigrants experience their situation in Norway

Birkeland (1990) had studied the life situation of elderly immigrants in the county of Oslo. The subjects interviewed were over 55 years of age. A major finding in the study was that many of the elderly immigrants were isolated and lonely. Those with a minimum family network and language barriers were the most effected. However, there were many elders who had good family networks that took care of them as well. The families were expected to provide care for their health and wellbeing. Many of the elderly immigrants in the study had very little knowledge of the health and welfare facilities available to them. Food traditions and language barriers had also hindered the use of these facilities.

Moen (1993) carried out a study to gain knowledge about the needs of health and welfare services among elderly non western immigrants in the county of Oslo (Gamle Oslo) and to learn their expectations concerning growing old in Norway. The subjects were from India, Morocco, Pakistan, Turkey, Vietnam and Iran and were over 50 years of age. The sense of being old was experienced at a much earlier age by some immigrants in contrast to their western counterparts. One's role in the family or society like being a grandmother, sicknesses and reduced health at an early age before and after their arrival to Norway, the heavy responsibility of having to work hard to support families in their home countries as well as in Norway were some of the reasons attributed. Some informants were burdened by tight economies, exhibited a higher rate of social dependence, and had poorer health and living conditions than ethnic Norwegians. Isolation from society had been a major obstacle effecting women the most as most of their life was spent at home where as the men visited cafes and the mosque. Addressing their health and welfare issues the informants had meant that they were poorly informed about the available services and had under used the

services. Most of the informants stated that they suffered from poor health. Only 2 out of the 27 informants interviewed had viewed their health as good. The family was expected to provide care and support that they may need as they grew older. But even though the social contact within the family had been fairly good there were indications of changing social patterns as the younger generations seemed to be less inclined to continue a three generation household as wished by the elderly. The attempt to continue living a similar life style as to their home country was made where cultural tradition and religious traditions were practiced when ever possible. Most friends were from a similar background. Social contact with the Norwegian society was very scarce. The results of the study indicated a greater demand for public services because of the change in the family structure and the willingness of the younger generations to take care of its elderly. It is expected that the younger and older generations will be living apart in some years to come unlike their present practices.

In a study conducted on the life situations of elderly immigrants living in Oslo in 1995, Dawes and Thoner (1997) interviewed 15 elders of Pakistan and Indian backgrounds between the ages of 50-82 years. Most immigrants in their study described them selves as having poor health. Staying healthy was meant to be important to be satisfied with life. The ability to function independent of others, take part in social activities and have a satisfactory income were associated to living a good life. Thus physical health was an important factor in the lives of the informants in the study. Very few informants in the study used the different types of health and social services available to them except for the doctor and social office. None of the elders had used either the day care centres or the home care services. The reasons were mainly due to the lack of information with regards to their rights and services available. Many of the elders in the study even switched from seeing a Norwegian doctor to seeing an Asian doctor due to language difficulties. Some had mentioned that they even consult doctors in their home country when on vacation. The women in the study preferred to go to a lady doctor at times of need. Traditional cures were also used by some as a supplement to western medicines at time of illness. At times the western understanding and for ill health had been taken into consideration only at times of acute need. Family gatherings and religious activities were considered important for their social life, health and well being, but many expressed loneliness and isolation, especially by those who lived by themselves or were less mobile. The elders who lived close to their families expressed less loneliness and isolation but almost all had expressed dissatisfaction in their total life situation due to a mismatch in reality and expectations. The

elderly showed almost total dependence on their children for their care and well being in contrast to the Norwegian elderly who are dependant on the state welfare and health services for their health and well being. Family based home care to maintain their health and wellbeing is said to function for some of the immigrants, but not for all. The elderly interviewed were worried about their economies as they grew older. Some of the interviewees had mentioned that they had experienced even being discriminated. Some considered returning to their native countries to spend the rest of their elderly lives.

Blom and Ramm (1998) carried out a study in 1996 on the living conditions among immigrants based on their education, work, economy, dwelling, social contacts, health, discrimination and other activities. Eight different minority backgrounds were represented within the age group of 16-70 years. Their report shows that immigrants when compared to Norwegians have on average a lower educational level, are exposed to greater hardships in their working lives and live in cheaper and more congested living conditions than an average Norwegian. In the age group of 45-66 years the number of immigrants who had reported to have chronic illness had represented a higher percentage than the Norwegians of the same age group.

Baluyot (1999) interviewed eight nurses in relation to home based nursing care extended to elderly immigrants and the cultural related problems they faced. Her study shows that minority elders may face disheartened Norwegian nurses who want to help but do not have the cultural knowledge and language capabilities to do so. Thus, she concludes that the future generation of nurses must have competence in culture care to cater to the increasing number of elderly immigrants if they are to help them and avoid frustrations. Her study shows that when serving elderly immigrants' nurses must take into account cultural values, traditional family structures and social factors in order to provide care that fits with the culture of the clients. An example from this study was that some of the elderly immigrants had wanted to be washed cleaned and groomed by their daughters. The researcher says that in such a situation the nurse should make allowance to include the member of the family by teaching and guiding the individual to carry out the procedure thus making room for culture care accommodation that fits with the culture of the client. In the same study nurses had encountered some elders using natural medicines such as herbs to maintain their health and well being. In such an encounter the researcher concludes that these practices should be maintained as long as they are not harmful to the individual.

Moen (2002) studied elderly Danish and Pakistani immigrants in Norway with the intention of comparing elderly people who have moved from a neighbouring country with

the elderly from a distant country. The study highlights perspectives that are required in understanding the lives of these elderly groups with the goal of providing care that suits their needs. An Ethno-cultural perspective, generational perspective, and a trans-national perspective are highlighted. From an Ethno-cultural perspective it is revealed that aging Danes and Pakistanis have differing adjustments and preferences for old age in Norway. Cultural identities are maintained where all the informants had described themselves as either Danish or Pakistani. The Danes exhibit an individual ethno-cultural adjustment and the Pakistanis an ethno-cultural group affinity. Family dependence or being with the family, maintaining their religious practices and visiting home was considered to be living a good life for elderly Pakistanis. Individualism and autonomy are given prominence by the Danes unlike the Pakistanis. The Danes consider the family to mean a lot to them but are not totally dependent on the family for their well being unlike the Pakistani elderly. Similar to Norwegians outside activities such as gardening, spending times in cabins, going to Denmark on holidays and other countries is considered valuable in maintaining their health and well being at an old age. Maintaining good health is considered a precondition for a good old age. Generational perspective; Living a good old age for elderly Pakistanis was found to be living in a multigenerational family. Some of the women's tasks were at home where they had no dealings with strangers whilst the men had had a greater flexibility to operate outside home. The men had the responsibility for contact and tasks in relation to the rest of the Norwegian or other societies. Both the men and women desired a Pakistani way of living surrounded by their families and networks in order to maintain a good life at an old age.

With regard to long term care the Danish encounter limited problems in using the care services offered by the Norwegian services, but some had brought up the issue of language as a hindrance to good communication with Norwegians. Some elderly Danes had expressed the wish of wanting to be with other elderly Danes. In contrast the Pakistani elders preferred their home surrounding in situations of long term care and many adult children had expressed their desire to keep their parents at home. It is assumed that this maybe as a result of traditions, social and financial obligations or the joy of living together with elderly family members. Achieving a home surrounding was sometimes aided by daughters in law who had grown up in Pakistan assuming that they were less influenced by the Norwegian culture. Some times being taken care of the family was also considered to be an alternative due to the lack of an alternative service or solution extended to this group

of elderly. Many of the Pakistani elderly are poorly equipped or prepared to live on their own, or to use the Norwegian long time residential care services.

Moen recommends that since many multi-generation families are willing to take care of their elderly, home based care service and benefits for the multi- generation family as a whole is assumed could promote good care for the elderly for their health and well being. When care plans are to be prepared for what type of assistance is needed, Moen (2002) recommends that the entire families' needs should be taken into consideration. Nursing homes or homes for the aged are said to be considered as a last resort and if were to be an alternative to reducing the burden on the family, many of the Pakistani elders in the study had preferred ethnically separated facilities with bilingual personnel. Based on the findings of her studies Moen (2002) recommends family- oriented care for elderly Pakistanis and individual oriented care for the Danish similar to what is provided for the Norwegians. The Elderly Danish were attached to their homes while the Elderly Pakistanis were attached to their families. The Danes had not wanted to move out from their homes but had wanted to manage on their own for long as they could. Whereas the Pakistanis did not want to move out of their families as they were dependant on the family to meet their caring needs. Many of the elderly Pakistanis did not have a home of their own and had moved around amongst their sons and daughters. Transnational perspective; is meant to be the affinity to both their home country and Norway and where much contact and time is spent in their home country. Pakistani elderly were shown to keep contact with their friends and relatives living in Pakistan and attended weddings, funerals, and even arranged marriages for the younger relatives living in Norway. Finances and ill health are also said to prevent some from spending time in their home country. Traveling to Pakistan or home was considered to be essential for good health and a good old age. A Pakistani elder is entitled to many health services and benefits as long as they do not spend more than six months out of Norway, many of the elders are said to be dependant on their social benefits and regulations are said restrict their mobility and long stays. The Danish elderly who wish to stay for long periods are not met with such restrictions since their rights are according European Economic Association (EEA) rules. Most Pakistani and elderly Danes in Moen's (2002) study wished to be buried in their native countries. The wish to be buried in their native countries is considered as a desire to return home by Moen (2002) and she assumes that the wish could be interpreted as a sign of not really settling down in Norway.

4.0. THE METHOD

4.1. The study's design

This is a qualitative study influenced by Leininger's (1995, 2001) theory of culture care, which attempts to discover, describe and analyse meanings and practices that are considered most meaningful to a Sri Lankan elderly immigrant in staying healthy.

Leininger (1995) defines theory as "a domain of inquiry, and question, or something to be explained, interpreted, understood, and predicted to gain knowledge" (Leininger, 1995, p. 97). The theorist identifies her definition of theory to correspond with the purpose of qualitative research where the idea is to gain a full understanding and meanings of a phenomenon under study in naturalistic context or familiar ways of those being studied. In developing the theory of culture care Leininger (1995) explains that she wanted to develop a research method in order to enter into people's worlds and let the people give their first hand ideas and experiences related to culturally orientated care. She further wanted people to teach her about their care meanings, symbols and practices in their culture. Knowledge gained from direct experience or directly from those who have experienced such knowledge is labelled as "emic" (insiders view) (Leininger, 1995, p.62). This is contrasted with "etic" (outsiders view) (Leininger, 1995, p.62) knowledge, which describes the professional perspective. Therefore Leininger's (1995) refers to her method of investigation as an ethno-nursing qualitative research method developed by her to obtain the peoples ideas, values, beliefs and practices of care and to contrast them later with nurses' knowledge. This is not an ethnographic study but a qualitative study involving verbal descriptions and subjective experiences of the informants themselves in their own surroundings but away from their country of origin.

The term "qualitative research" (Corbin and Strauss, 1998, p.10) mean any type of research that produces findings not arrived by statistical procedures or other means of quantification. In this study the aim is to obtain subjective descriptions and not data consisting of numbers. Corbin and Strauss (1998) mean that there are many valid reasons for qualitative research. One reason given is the nature of the research problem. They mean that certain areas of studies naturally lend themselves towards qualitative type of research, especially research that attempts to uncover the nature of a persons experience with phenomena, e.g. like illness, lived experience and culture. The nature of this study revolves around phenomena of health and culture and the informants' meanings and lived experiences. Corbin and Strauss (1998) also state that qualitative methods can be applied to

uncover and understand what lies behind any phenomenon about which little is yet known, or that it can also be used to gain fresh perspectives of things which quite a bit are already known. Web and literature searches have revealed that research on Sri Lankan elderly immigrants in general has been neglected.

4.2. Recruitment of informants

Convenience purposive snowball sampling as described by Polit & Beck (2004) was used to recruit and collect data from seven elderly Sri Lankan immigrants. Although their mother tongue was Tamil, informants fluent in English were recruited for the study as to avoid misinterpretations during gathering, translation and analysis of the data.

Those living at home with no physical or cognitive handicaps were recruited for the study. The informants were between the ages of 50 -75 living in the country for over a period of at least ten years. An age limit of 50 years and older were set as earlier studies (WHO, 2001; Moen, 2002) had shown that elderly from developing countries had considered themselves as being old much earlier than the elderly from developed countries.

The initial participants were introduced by contacts in the Sri Lankan community. These participants further referred other participants who volunteered to take part in the study on inquiry. Non probability convenience sampling “entails using the most conveniently available people as study participants” (Polit and Beck 2004 p. 292). Snowball sampling also called network sampling or chain sampling is a variant of convenience sampling. With this approach, early sample members are asked to identify and refer other people who meet the eligible criteria. This method of sampling according to Polit and Beck (2004) is often used when the research population is people with specific traits who might otherwise be difficult to identify. The population of elderly Sri Lankan immigrants above 50 years of age is so little compared to most other non western elderly immigrant groups, therefore identification and recruitment is not easy.

Polit and Beck (2004) state that snowballing begins with a few eligible study participants and then continues on the basis of referrals from those participants until the desired sample size has been obtained. The intention was to interview an equal number of men and women, but it was a difficult task in recruiting women. Except from one of the female informants, there was no response from three of the other anticipated informants. Two additional males were interviewed due to the difficulty in recruitment of female informants. It was assumed that the reduction of the sample size would be of little significance for the outcome. According to Kvale (1996) the number of subjects necessary,

depends on the study's purpose and due to the in-depth nature of qualitative studies and the analysis of the data required, it is advised to have quite a small representative sample. Five of the informants were northern Tamils with Hindu backgrounds, one a northern English and Tamil speaking Muslim and one a Tamil from the west of Sri Lanka having a Christian background. There are a few Sinhalese Buddhist and Christian immigrants who also constitutes to this diverse ethnicity of Sri Lankans, but none were found for this study. Therefore the reference to Sri Lankans was intended to associate all ethnic groups living in Norway immaterial of their home based cultural backgrounds, but the informants represented in this study reflect the majority of Sri Lankans living in Norway, namely the Tamil speaking community.

4.3. Data collection

Qualitative semi structured interviews lasting an average of one hour were used as the method of collecting data. According to Polit and Beck (2004) in semi structured interviews, a researcher prepares in advance a written topic guide, which is a list of areas or questions to be covered with each respondent. The interviewer's function is to encourage participants to talk freely about all the topics on the list, and to relate stories in their own words.

4.3.1 Formulation of the interview guide

A pilot study was conducted in the spring semester of 2005 using only the initial question of this interview guide. Based on the outcome and understanding of the pilot study adjustments were made and a semi-structured interview guide was added to this study (appendix, 7). According to Polit and Beck (2004) a pilot study is a small scale version, or trial run done in preparation before a big study to test protocols, data collection instruments, sample recruitment strategies, and other aspects of a study.

A research question directed by Jan & Smith (1998) on their studies on Pakistan immigrants living in the United States was referred to when formulating the initial question. The initial question of the interview was formulated in an open manner so as to get the participants to talk freely as possible. Leininger's (1995, 2001) social structure dimensions from the theory and sunrise model were included to guide the interview.

According to Leininger (1995, 2001) the nurse could begin anywhere in the model according to the area of inquiry being assessed or the special interest of the nurse. In this paper, special interest has been given to the social structure dimensions of the model. Thus the major areas of assessment in the guide are economical, educational, kinship and social

factors, religious and philosophical factors, cultural values and life ways, political and legal factors, and technological factors. The theory and model has been presented in chapter two of this paper.

4.3.2 The language

All interviews were conducted in English due the language skills of both the researcher and informants. Being a British colony English was the official language in Sri Lanka until 1956, therefore most elders of the study's cohort speak English. Finally by the study being conducted in English, it was assumed that during gathering, transcription, description and analysis of the findings, the chances of misinterpretation would be a minimal strengthening it's validity.

4.3.3 The site of the interview

The interviews were held at the informants' places of residence. Carrying out the interviews in their homes was preferred due to the relaxed atmosphere around them. Kvale (1996) encourages the interviewer to establish an atmosphere in which the informants feel safe enough to talk freely about his or her experiences or feelings.

As to concentrate on the topic and the dynamics of the interviews, data was recorded on a micro audio tape recorder. Brief notes were also maintained to facilitate later analysis.

4.4. Data analysis

The purpose of the analysis is to arrive at a deeper understanding of the meanings and practices in staying healthy as experienced by the informants.

Polit & Beck (2004), mention that qualitative data analysis is a particularly challenging enterprise. They mention three main reasons for this: first there are no universal rules for analysing and presenting qualitative data. Second, there is an enormous amount of work required, one must organise and make sense of the narrative material. Thirdly qualitative researches must balance the need to be concise with the need to maintain the richness and evidentiary value of the data. However, the same authors mention that even though there are no universal rules, there are different approaches developed to aid analysis. The following approaches and steps have been attempted in the data analysis in order to present the findings in this paper.

4.4.1 Analysis style

A template analysis style was applied. In this style (Polit and Beck, 2004) the researcher develops a template or analysis guide to which the narrative data could be applied. In the

case of this study the semi structured interview guide based on the Social structure dimensions of Leininger's theory was also incorporated to assist the guidance of the analysis and organise the transcribed data. Morse and Field (1995) refer to a similar method which they refer to as question analysis, where the questions could be used to organise the data.

4.4.2 Analysis during data collection

According to Polit and Beck (2004) data collection and data analysis occur simultaneously. The search for important themes and concepts begins from the moment data collection begins. Probable themes were noted down, coded by hand and notes were maintained to facilitate the process of analyzing. According Kvale (1996) immediate impressions communicated and noted may provide valuable information for the reflection and analysis of transcripts.

4.4.3 Transcribing

Each recorded interview was transcribed progressively and prepared for further analysis. This means preparing the interview material which was tape recorded to a written text for further analysis. According to Kvale (1996) it involves a transcription from oral speech to written text.

To get an overall understanding and reflect over the recorded material, the individual recordings were listened to before transcription, unclear areas were played over to clarify and clear any doubts or misunderstanding of the words or sentences.

Otherwise the written text is a repetition of the taped material except for a few necessary omissions where incomplete, unclear sentences and pauses have been edited.

Transcribing of the interviews was also helpful too in getting familiar with the data, especially with regards to its contents and the expressive tones of the informants.

At the end of each interview the informants were asked as to weather they could be contacted if further clarification was required.

4.4.4 The analysis proper

After transcription "The analysis proper" (Kvale, 1996 p.190) involves developing the meaning of the interview data and bringing into light new perspectives on the phenomenon being studied. Van Manen (1990) says that the meaning of a phenomenon can never be gasped in a single definition. According to Van Manen (1990) "Human science meaning can only be communicated textually by way of organized narrative or prose" (Van Manen

1990, p. 78) and that is why the researcher should engage in the reflective activity of labouring through a text. In order to come to grips with the structure of meaning Van Manen (1990) says that it is helpful to think of the phenomenon described in the text as approachable in terms of meaning units, structures of meaning, or themes. Reflecting on lived experience then becomes reflectively analysing the structural or thematic aspects of the experience. In the case of this study, the transcribed data was read many times to get an overall understanding and analysed to identify meaning units, themes and categories that describe the meaning and practices of staying healthy. The analysis guide was used as an aid to help code the themes and categorize the findings from the transcribed data. According to Graneheim & Lundman (2003/ 2004) a meaning unit is a group of words, sentences, paragraphs or statements that relate to the same central meaning. Polit and Beck (2004) define theme to be “a recurring regularity emerging from an analysis of qualitative data” (Polit and Beck 2004, p.734). Van Manen (1990) goes on to explain that thematic aspects of experience can be exposed or isolated from subjects descriptions of the experience by three methods:

- 1) Holistic approach where the text could be viewed as a whole and try to capture its meanings.
- 2) A selective approach, where statements or phrases that seem essential to the experience under study could be highlighted or pulled out.
- 3) And a detailed approach where every sentence is analysed.

Graneheim & Lundman (2003/ 2004) mean that one of the basic decisions in an analysis is selecting the unit of analysis, and they suggest that the most suitable unit of analysis is the whole interview that is large enough to be considered a whole and small enough to be possible to keep in mind as a context for the meaning unit, during the analysis process.

A vast array of data was gathered by the initial question from all informants as it was formulated in quite a deep and wide manner, the areas to be covered by the interview guide were often addressed, therefore this gave rise to consider the whole interview as the unit of analysis for each informant. Van Manen (1990) says that as one continues the study of the lived experience descriptions and distinguish the themes that begin to emerge, then one could note that certain experiential themes reappear as commonality or possible commonalities in the various descriptions gathered. The main task then is to hold on to the emerging themes by lifting appropriate phrases or by capturing in simple statements that are the main driving force of the meaning of the themes. Common thematic statements were extracted from each interview. Then the appearing common descriptions were

systematized in categories of commonality across the informants based in relation to the social structure dimensions of the Sunrise model, namely; economical, educational, kinship and social, religious and philosophical, cultural values, beliefs and live ways, political and legal, and technological factors. Themes with extracts from the text are presented in section 5.0 of this paper under the heading; Presentation of the findings.

4.5. Ethical Aspects

The study does not include patients but healthy elderly Sri Lankan immigrants living at home with no physical or cognitive handicaps. However, the study was requested to be presented to the Regional Ethical Committee for evaluation and their advice alterations and recommendations have been followed before commencement (appendix 1-6). Probable informants were informed about the study by mail and those who wished to participate mailed an informed consent in return (appendix 3 and 6). The participants also had the possibility of obtaining further information by phone and e-mail from the student. All sensitive data is made confidential. Interview recordings and notes were obtained with consent, and transcribed over again. All recorded and identifiable material was erased on completion of the data analysis.

5.0. PRESENTATION OF THE FINDINGS

5.1 Economic means and health

The drive to succeed economically is of vital significance for the Sri Lankan elderly to maintain their health and well being.

5.1.1 Maintaining economic success

Being employed or having a satisfactory income meant leading a healthy life as then one had sufficient means as to get what one needed. However, managing according to one's means was equally important for one's health, because over exerting one self as to have more money was claimed to cause stress, fatigue and ill health that eventually can end up in a bad cycle of events such as neglecting one's family and falling into financial difficulties. Unemployment and lack of adequate wealth also meant to cause stress, ill health and displeasure amongst family members, especially one's spouse and children.

The economic success of their children and grand children were of great importance in maintaining a happy and healthy life style to some. In addition to the limited welfare benefits they were entitled, some above retiring age either worked or exhibited economic and housing support from their children to stay healthy. Maintaining economic success also meant having sufficient money to support ones relatives that in turn was meant to give happiness and good health.

Being employed and having an adequate income for ones daily expenses. Health was thought to be linked to one's economy or work. Having enough money for ones daily expenses was important. Not having enough money meant to cause displeasure amongst family members, especially one's spouse and children resulting in stress and ill health:

“Money, enough money for your daily expenses keeps you healthy. If you don't have enough money too you have problems; you tend to argue with your spouse and children.”

For one informant yet under retire-ring age being employed too meant leading a healthy life as then one had adequate means as to get what one needed. Uncertainty with regards to being employed causes fear and distress:

Being employed plays an important part of my being healthy, I manage to buy what I need, but I just have a two years contract and just have to keep my fingers crossed hoping to get some sort of work once my contract expires.

For one informant who was advised to find alternative employment, being unemployed meant having financial difficulties. Having financial difficulties had brought about stress in his life:

I get very stressed up at times since I have less money in my hands now after I had to give up my job. For example if I get a bank giro that I have to pay immediately and I don't have the money I get very stressed.

To be financially stable one of the eldest informant's who was above retire-ring age said that he had to work, especially in the weekends which he meant was not such a good thing for his health at his age:

Economy plays a part, I get less money than before, I work less than before, it would have been better if I could have earned a little more money so that it would have made me a bit more financially stable, therefore I work in the weekends and that's not such a good thing for my health at my age, but unfortunately I have to work.

Managing according to one's economic means. Managing according to one's economic means was meant to be important, because over exerting oneself as to have more money too meant to cause stress and ill health:

Every human being has ambitions, they want to have everything, food is a necessity, shelter and maybe a car to get about, but it's important that we manage within our means. But some tend go above their means and live a stressful life.

The same informant meant that to meet one's financial commitments people are often compelled to work hard which eventually can lead to a bad cycle of events. Working hard was meant to bring about stress and neglected family relationships where often the quality time spent with one's children was a minimal. In order to compensate for one's absence from home the children were often showered with gifts which was meant to be an unhealthy way of living:

To make ends meet and pay up your bills some people have to work hard. Working hard puts stress on their health and family relationships, children are neglected, it's not that they don't love their children, but they don't see them, they show their love by buying them everything they ask for, it's a bad cycle of events.

Economic success of children and helping relatives in need. Financial security, support and presence exhibited by one's successful children as well as helping relatives in need gave happiness. Being happy was meant as staying healthy:

Right now I am not in great need, I get my stately allowance, and my children provide me with food and shelter, what more do we need, well I do help some of my relatives back at home if do get a bit of extra cash in my hands. Being with my children and helping those in need makes me happy. Being happy is staying healthy.

Having sufficient means to help those in need, especially relatives in Sri Lanka gave happiness. But helping relatives in Sri Lanka was also meant to be a duty:

We came here with our bare hands, worked hard to achieve what we have today, support our selves and even support our families in Sri Lanka, but after all it gives me happiness to help those in need, and it is also a duty that we have to fulfil.

5.2 Education

The findings reveal that like economic success, educational success too is of vital interest to the Sri Lankan elderly to maintain their health and well being.

5.2.1 Achieving educational success

Achieving educational success was greatly valued by the Sri Lankan elderly as a mode of living and maintaining a healthy life style. This belief is exhibited by their present achievements, keenness to educate themselves even further at an elderly age and their eagerness to educate their children. The eldest of the informants already have well established children who see to the health and well being of their parents. The children either fulfill or are expected to fulfill their responsibilities in caring for their aging parents. Education is believed to bring honor, prestige, wealth, happiness and generally a better life.

Educating oneself and the children. Educating oneself and one's children was a familiar theme that was meant and practiced by most of the study participants to maintain health and well-being.

Even though the education one had taken could not give related employment to one of the informants, he had managed to get employment in another field and spent a great effort in trying to educate his children. The informant assumes educating his children is an investment that brings him mental satisfaction and maybe a secure old age as he expects his children to take care of him and his spouse as they got older:

I educated my self in the construction sector, but at that time it was difficult for me to get work in this sector, getting employment for most people during this time was difficult in this sector but then again I just took what I got in a different field. Even though I could not make proper use of my education I am keen on educating my children, in fact one of my children has just started studying medicine, educating them means mental satisfaction and may be a secure old age for me and my wife too. I assume they would take care of us in return, lets see, time would tell.

Another informant meant that due to his education and hard work he has the pleasure of relaxing and enjoy the life he leads today. He had managed to educate his children as well who are now well established:

Due to my education and hard work I managed to secure the life we enjoy today. I managed to educate my children too and now they too are well established what more

can you ask for, now I have the pleasure of relaxing and enjoying my life with the rest of my family.

Educating one's children and grandchildren gave another participant pride, the feeling of psychological well-being and a sense of security:

The joy of educating our children to the present positions they are in today gives us great satisfaction and security which I would say keeps us healthy too and what I enjoy most is to watch my grandchildren too doing well.

The rewards of educating ones children is seen as a possibility that the children in return would ensure that their parents' lead healthy and comfortable lives: *"Very often it is my children who insist or see that both my husband and I live healthy lives, they being educated give us quite a comfortable life"*.

Even though arriving in Norway as an adult, education was considered and was meant to be an important factor for having a better future and leading a healthy life. Although the process had been long and not always resulted in job satisfaction, yet education was deemed important. The informant stressed that he could have been happier if he had got work in his relevant field of education:

I came here as an adult but I continued to educate my self with the intention of a better future and a healthy life. Even though I had a basic education it was a long process, studying the language doing the required subjects and spending many years on a school bench, but then again I have gained definitely quite a lot but I would have been even more happier if I managed to get employment in my educated field.

5.3 Kinship and family structure

The Sri Lankan elderly exhibit close interdependence within family and friends in order to maintain their health and well being or recover from illness.

5.3.1 Maintaining friend and family support

Caring and being taken care of family and friends, meeting friends and sharing health related information and returning home to relatives and friends were meant and practiced to maintain their health and wellbeing.

Those with extended families live either together or in close proximity to each other readily available to extend help when needed. Informants who had no immediate family, a limited family net work, or who exhibited fright in not been taken care by their children at an old age preferred to return to Sri Lanka to live with relatives.

Five of the informants were living with their immediate families, of which two were living with their extended families consisting of their children, spouses and grandchildren showing dependence and performing different roles and activities within. Two of the informants were taking care of their grandchildren whilst their children and in-laws were at work. They meant it was their pleasure and duty to care for their grandchildren. The informants also meant that it was a duty for their children to take care of them at an old age. Not living with the children meant living in mental agony and sense of helplessness. A sense of duty, responsibility and obligation is exhibited to maintain good health within the family. The only women in the study depended on socio-economic support from the family. In the mean time she played a central role in the care, health and wellbeing of the rest of her family. Being taken care of the family and taking care of the family meant staying healthy for her.

Caring and being taken care of family and friends. For one man the support and advice of his spouse was meant to be an important aspect of him staying healthy: *“My wife keeps watch over my food, she advises that it is time to go for checkups, if I say that I have some problems, she tries to give me positive advice.”*

Those who have extended families live either together or in close proximity to each other readily available to extend help when needed. Living in the same dwelling or in close proximity to one’s children and grandchildren was meant and practiced to stay happy and healthy. For the same informant having close friends was important to stay healthy as well:

Living close to my children and grandchildren means a lot to me. I live with one of my children and his family, and my other children live in close proximity. It plays an important part in my life in staying happy and healthy. I do have some genuine friends, who also do play an important part in my life, but unfortunately they do not live here, but I correspond with them regularly.

As for one informant, the spouse, children and grandchildren played important roles in keeping her healthy. The children extended care to her and her husband, while in turn the informant and her spouse took care of their grandchildren when necessary. She stressed that she would have been quite isolated and helpless without her children around her:

My husband, children and grandchildren are very important to me. Our children look after us, and we look after our grandchildren when necessary. I would have felt quite lost and helpless not living with my children, I am sure they would continue to take good care of us.

One informant meant that maintaining health and wellbeing at an old age was being taken care of the family. Expecting Socio-economic support from the children was clearly expressed: *“Maintaining good health at an old age means being take care of the family. As Sri Lankans we expect our children to care of us.”*

At times of sickness it was considered important to have family and friends around one to recover:

We do have some friends too that we meet once in a while. They either come over to us or we go over to them. It’s important at times of sickness that your family and friends are around you, it helps.

Having a good social network of family and friends was believed to help one relax, avoid stress and isolation as one informant said:

Meeting friends and being around friends and family helps against stress, on weekends, Saturdays and Sundays we meet some friends for a party and spend three, four, five six hours when we are free, we don’t feel anything, we chat and that helps us to relax.

Meeting friends and sharing health related information. A way of maintaining good health was also meant to be discussing their sicknesses and ailments or treatment received amongst friends. Information was also exchanged between friends about the health services and expertise available, or from where one could obtain advice in times of illness and need:

We have a few friends that we meet for example at parties. We discuss are sicknesses and ailments and treatments we get from the doctor and health centres. Through my friends we get information about health centres, specialist etc.

Cultural festivals were eagerly awaited to as away of maintaining good health. These festivals brought family and friends together, gave one the opportunity to make traditional food, and discuss events going on in Sri Lanka as well as discuss ones ailments and treatments:

We have a few cultural festivals in the year, I look forward to them as then I meet and gather with family and friends, we make Sri Lankan foods and discuss a lot of things, things that are going on at home, and we discuss our ailments and treatments. In addition to our own festivals, we also celebrate during Christmas mainly due to our grandchildren, they look forward to it.

Returning home to relatives and friends. Returning to Sri Lanka either on holiday or to help and live with family and friends was exhibited in most conversations in order to stay healthy as one grew older. Having friends and helping people in need is considered to

give health and happiness. The thoughts of returning to live in Sri Lanka was greater among those who did not have children or relatives in Norway and by those who did have children but exhibited a doubt of not being cared for by them. Sometimes, a certain uncertainty was expressed and spiritual guidance was looked for comfort. As one informant said:

Having friends and helping them more than them helping me gives me happiness and health, I do not have children but I do have friends, but not having children I would like to return home as I get older. In Sri Lanka I have my brothers and sisters and their children. If I fall ill when I am older I am sure my family will take care of me in Sri Lanka, in fact I am a bit uncertain about my future, but after all it's in Gods hands.

Some do exhibit a doubt as to whether their children would take care of them when the need arises. They express being caught between two cultures and experience attitudes of their children to be changing. It is meant to be a difficult decision to make now, but the preference of returning to Sri Lanka are in their thoughts in order to maintain health and well being. In case they do not return home they would at least prefer staying close to their children rather than being institutionalised:

It is difficult to take a decision now, but I would like to return to our own country, but depends also on our children, if they would take care of us. Actually we don't have such a strong culture as our home country, we our living in two cultures. There is always a doubt as to whether our children would take care of us. In case we don't go home I would prefer staying nearby my children but don't prefer being institutionalised.

The fright of living an isolated life as one gets older in Norway was expressed, especially by those not having any other immediate family around them. Therefore the thoughts of returning to Sri Lanka to live with family and friends as one gets older was meant to be a way of living a healthier life:

The political situation is a factor that keeps man away, but man can always return, living with friends and relatives is better for health. Here we feel that we might end up living a lonely life when we become pensioners. We keep worrying about the future. If you live with friends or relatives so the time will go very smoothly. Except for my wife and family I don't have any other immediate relatives living here.

I have a lot of friends and relatives I visit in Sri Lanka, and look forward to meeting them every time. I do miss Sri Lanka, my friends and relatives. At times I consider returning to Sri Lanka, I have a feeling that here we might end up leading a lonely life, if you live with friends and relatives you do not feel the time go by.

In times when one's health has deteriorated it is expected or hoped that the family will have the possibility to help in order to recover. It is assumed that care would be gladly

exhibited by the family since it is a cultural tradition, but yet one leaves it as an open option for the family to decide:

I hope and pray that my family will have the possibility to help me when needed, I think so, they would be glad to do so, that's our tradition, our culture, but it is left to them if they feel comfortable to that then it's left to them.

Having vacations meant maintaining health and wellbeing, where a person was considered to completely relax and forget about all other events. Going to Sri Lanka on vacation was preferred but the cost was considered to be high to travel often:

It's good to go home for holidays and completely relax and forget about all other things, holidays are needed for relaxation. For seven years I haven't been to Sri Lanka, before that I had not been there for thirteen years. It costs a lot to travel often.

5.4 Values, beliefs & life ways in staying healthy

Staying healthy meant maintaining or practicing beliefs, behaviours and activities that facilitate health.

5.4.1 Maintaining beliefs, behaviours and activities that facilitates health

Diet and religion were closely associated and played a central role in their meanings and practices in staying healthy. Conscious of what one eats and maintaining good health habits such as: proper nutritional intake, going for regular checkups and seeking professional advice and treatment, adequate sleep, keeping one self occupied and having a positive mental attitude, yoga and meditation, exercise and sports, and avoiding stressful situations were meant and practiced to stay healthy. Uncertainty was also expressed as to whether eating Sri Lankan food was healthy, but not eating food that one is used to was meant to limit satisfaction. Thus, consuming food that one liked was meant to give emotional satisfaction. Being satisfied meant staying healthy.

Seeking help from the western medical profession at times of sickness dominates their meanings and practices, but traditional remedies and alternative practices are used at times of mild illnesses or when Western medicines does not seem to cure their illnesses.

Being understood and receiving the proper treatment when seeking professional medical advice was also meant to be important in staying healthy.

Maintaining religious and healthy eating habits. Diet, religion and awareness of what one ate were closely associated and played a central role in their meanings and practices in staying healthy.

One informant meant that she was a vegetarian primarily due to her religious beliefs, but meant that eating vegetarian food was very healthy as well. The rest of her family were not strict vegetarians and ate non- vegetarian food except for one day in the week:

I am a strict vegetarian. I am a vegetarian mainly due to my religious views, but I think eating vegetarian food is very healthy. I have managed to maintain eating vegetarian food, but not the rest of the family, they generally eat all types of food, but abstain from meats or fish at least once a week.

Some ate vegetarian food in their homes as it was considered to be healthy and in accordance to their religious teachings, but at times they do eat meats when served outside as not to displease their hosts:

I try to eat vegetarian food but some times I go out some where and change, I don't tell my host that I don't eat meats, but I try my best to eat vegetarian foods due to my religion and I think it is healthy too.

Some had even changed their eating habits after living in Norway for some time. Vegetarians had started to eat meat but were careful not to overdo it. Like one informant stated: *"I am a vegetarian, I started taking meat food after I came to Norway, but I am very careful, I don't eat very much, I control my self even if the food is very good."*

Staying healthy meant having a clear religious conscience as to what one ate. Like for the Muslim informant eating Halal meat was considered important for his health: *"We eat only Halal meat, which is a special way of slaughtering, so I would say Halal is important to me when it comes to meats and foods."*

Being conscious of what one eats and maintaining good habits. Proper nutritional intake, significance of food and maintaining good habits were meant and practiced immaterial of religion to stay healthy. One informant said:

I get up in the morning, brush my teeth and drink a glass of water in fact I make it a point to drink six glasses of water a day. Vegetables and fruits make a large part of my diet. An apple a day keeps the doctor away. I eat four meals a day and I like eating Norwegian food, in fact I eat more Norwegian food than Sri Lankan food since it's cooked less, much greener and healthier.

One informant stressed the significance of his diet and eating habits in keeping healthy. Fish and vegetables were considered to be healthy and eaten regularly: *"My diet and eating habits are quite important in me keeping healthy. Fish and vegetables is an important part of my diet."*

Some informants tried to maintain good health by trying their best to eat, drink or do what they thought was healthy. Consuming ecologically grown food, vegetarian or fresh foods, lots of fruits and exercises on a regular basis was meant to be healthy:

I try to be or do healthy things; eat ecological food, if not fresh vegetarian foods. I try to eat vegetarian foods but some times I go out some where and change, I don't tell them I don't eat , but I try to eat vegetarian foods , fresh foods, lots of fruits, exercise so that should keep a man healthy.

Another said: *“I jog every day, I don't take coffee and tea, I drink milk, and I take two cups one in the morning and one in the evening. I drink a lot of water, hot water with ginger if I can.”*

Consuming food that one likes and satisfaction. Uncertainty was also expressed as to whether eating Sri Lankan food was healthy by another, but not eating food that one is used to, meant to limit satisfaction. Therefore eating Sri Lanka food as often as possible was considered to give happiness and satisfaction. Being satisfied meant staying healthy:

I don't know whether Sri Lankan food is healthy, but it is tasty, because we have got used to it, so I try to buy things and eat much Sri Lankan food as I can. I eat rice and curry. Some times I eat rice and curry three times a day. But I eat at least one meal a day of rice and curry. If I don't eat it I am not satisfied. Some times I try to make some Norwegian meals and eat like potatoes, supps, but it is not having my own meal but if I eat rice and curry I am happy and satisfied. To keep healthy one has to be satisfied.

Taking regular checkups, seeking advice and receiving the proper treatment.

Going for regular checkups, seeking advice and receiving the proper treatment was meant and practiced to keep healthy by some.

One informant meant that staying healthy was taking care of oneself by going for regular checkups and seeking advice and living up to the advice received: *“I go to the doctor for regular check ups and follow his advice when ever necessary; in this manner I try to look after my self.”*

Another informant meant that going for regular checkups and getting the proper treatment when required gives her a sense of security at her age: *“Maybe going for regular checkups and getting the proper treatment when required gives me a sense of security. After all I have come to an age that one has to live day by day.”*

Having proper sleep. Having adequate sleep was meant to be an important factor in staying healthy for an informant:

I generally go to bed by about 10 pm and try to have a good night's sleep. I avoid eating a heavy meal at night, if I eat a lot at night I spoil my sleep. It is important that I sleep well. I try to sleep between 10 pm and 6 am but some times due to my other work I have to change.

Keeping one self occupied and having a positive mental attitude. Keeping one self occupied and maintaining a positive mental attitude was meant and practiced in staying healthy. Particularly one of the eldest of the informants in the study attributed the belief of being occupied as his main reason of maintaining good health. Whilst another mentioned that after he had given up his job he believed that his health deteriorated since he had nothing much to do and this gave rise to financial difficulties, disharmony within the family, frustrations and stress.

The eldest informant meant that he had a goal to keep him self occupied in order to keep healthy:

Not necessarily only in Norway, any where in the world, where ever you live, you have to be healthy, if you are healthy then you don't have other problems, you should have a goal and then go for it and if you are unhealthy then you cant do that. I keep my self occupied.

Another informant meant that a positive mental attitude and a goal in life that keeps one self occupied was important too to keep healthy. One was expected to have a goal and work towards it. Having a goal and working towards it was meant to keep a person busy. Being occupied and busy meant that the individual had less time to think or complain about ailments as one had to concentrate on one's work:

I always think if I think positively that is most important to keep healthy. Because then most of the time everything comes out positive. Positive mental attitude, you must be occupied and another thing I want to tell you is that you must have a goal and go towards that. Even if it takes two years to realise your goals for example say that you want to start a business this will keep you occupied and in that mind your health wouldn't be much affected. Most of the busy people don't complain that they have a sickness because most of their concentration is on their work. If you keep your self busy there is no time to think about other things. I believe in that very much. I have read so many articles about this.

Another informant had been advised by his medical consultant to change his type of work as it had affected his spine. He had found it difficult finding suitable new employment. He

attributed the difficulty in finding employment due to his age. Not working was meant to have caused him mental distress, financial difficulties, frustration, stress and disharmony within the family. To cope with his new situation and keep healthy he tried to keep himself occupied with other activities such as meeting friends, reading and watching TV. Reading books on psychology in addition to keeping himself occupied is said to inspire him too to cope with some of his problems:

I was advised by my doctor to get another type of job, I was working 17-18 years in one place and that affected my back. I followed his advice but found it difficult finding another job, but it is very difficult now to get work at my age but I am trying. I feel that in fact mentally I am not so happy and feel sick at times after I stopped working. I have less money in my hand, I get frustrated and stressed much easier than before and make life uncomfortable for my family too, but I try my best to keep myself occupied with other activities like meeting friends, reading and watching TV. When I keep myself busy I worry less, I like to read books on psychology, it is very interesting and some times give me answers to solving my problems.

Practicing yoga, meditation and being active. One of the informants who attributed the belief of being occupied as to the main reason to staying healthy also meant that yoga and meditation has dominated his activities for many years in order to maintain good health. Yoga and meditation is said to give him the feeling of staying young, strong and energetic:

Now in my case I am 65, going to be 65 and I am still doing my third degree, I keep myself active and occupied and so far thank God, I haven't had a serious illness. I started doing yoga when I was 12 or 13 years old and I still continue, that means for the past 52 years I have been practising yoga, to be honest some people estimated me to be 25 when I was 43 and recently my employer where I work part time wanted to know why I needed an extra week of vacation, when everybody else gets only 5 weeks, he was quite surprised to hear that I was almost sixty five.

For the past 25 years I have been meditating. I meditate two hours a day, one hour in the morning and one hour in the evenings, but that one hour also includes yoga, first I practise yoga followed by meditation, this gives me a sense of great power and energy.

Exercise and sports. Exercise and sports were meant and practiced to stay healthy. Whilst some train on their own initiative, some train due to the advice given to them by their doctors. While some went for daily walks others were active with sports. One informant meant that he kept himself active and fit by training with sports like tennis, swimming and jogging long distances. Out door activities seem to dominate their training activities as a method of keeping them healthy. Whilst the weather was an influencing factor in the ability to conduct these activities to one, for another the weather did not seem to be a hindrance.

For one informant staying healthy meant taking a daily walk for about an hour: *“Taking a daily walk keeps me healthy, I walk for about an hour.”*

Whilst for another informant staying healthy meant going for a daily walk with her husband after attending to the needs of her family:

I walk every day with my husband, I get up early in the morning around 05.30 am in the morning, prepare meals for the rest of the family, my children and grand children with whom I live with. After they have left for work and school I tidy up, have a wash and go for a walk.

Another informant meant that he was advised by his doctor to exercise and therefore he now walks and cycles in the summer as to keep healthy but avoids outdoor activities in the winter: *“The doctor advised me to exercise, so now I walk and cycle in the summer but not in the winter.”*

Whilst for another informant the weather was not a hindrance. Actively participating in sports activities throughout the year in order to continue living healthy was expressed: *“I am a sportsman, I play tennis, I swim, I do jogging every day, even in the winter I jog a long distance.”*

Avoiding stressful situations. Stress and its relation in trying to maintain a healthy life was mentioned by many of the informants. Whilst one showed that he coped with stress in a positive manner, two of the informants strived hard to cope with stressful situations. Stress factors mentioned by the informants were, neighbours and family members, work and finances, deficiency of a family network and adjusting to a new way of life.

Maintaining good health meant trying to avoid stress, provocation and anger to one informant: *“Trying not to stress and getting angry keeps you in good health. If your neighbour or a relative says something let him keep on talking, he would talk for three days and then give up”.*

Whilst for another informant trying to lead a stress free life meant trying to maintain or lead a healthy life. Many of the small ailments the informant had were meant to be due to stress. Economic reasons were attributed to as being a main stress factor:

Most of the small ailments I have are due to stress, I try my best to lead a stress free life by trying to keep my self occupied after I had to give up my job, but at times it is unavoidable like for example when I get a bill to pay that I have to pay immediately and I don't have the finances.

Mentally we are not 100% happy to stay in Norway it is quite stressful the money that comes in goes out again.

Another associated stress to be one of the worst factors contributing to ill health. Performing necessary daily activities of life, family responsibilities and burdens were meant to cause stress. The lack of a family network in Norway that could have helped out at a time of crisis meant to be a contributing factor to stress as well:

Stress is the worst thing. What stresses me most is that after work we have to make food our selves, spend time with our children in the weekends drive them around for extra curricular activities such as to learn our mother tongue and learn other cultural activities, but back in Sri Lanka a positive thing is you have your relatives who could help you out, but here we lack that help.

Being understood. Being understood and receiving the proper treatment means maintaining good health. Whilst for one it did not matter whether he received treatment from a Norwegian or Sri Lankan doctor, for some informants it did matter. However, the main factor was being understood.

Being understood was of vital importance to one informant immaterial of whom he received treatment from to stay or remain healthy. Both positive and negative factors were highlighted in receiving treatment from either a doctor of Sri Lankan origin or a Norwegian doctor:

When I am ill it doesn't matter whether I go to an Asian or Norwegian doctor, the main thing is that they understand me, my illness and what I am saying. There are both advantages and disadvantages, may be a Sri Lankan doctor might understand me better but the attitude of treatment generally differs, you know we Sri Lankans believe in receiving medicines at once, the idea of just receiving something at once makes you feel better, but on the other hand a Norwegian doctor would ask you to do some test before treating you, and the treatment is generally based on results of the test.

One informant had changed over to a Sri Lankan doctor meaning that it was much easier to explain his problems and ailments. The doctors understanding of the clients cultural background was meant to be significant to be understood and for the treatment prescribed:

My primary doctor is a Sri Lankan, actually I had a Norwegian doctor earlier but after I was introduced to a Sri Lankan doctor I changed over to him because it is much easier to explain my problems and ailments to him, he too understands our culture and I feel quite comfortable talking to him, he sees things from our angle.

Another informant meant that going to a Sri Lankan doctor gives a sense of comfort as it is easier to explain and talk about other things and feels understood as there are certain things that are difficult to explain in Norwegian:

I don't have objections going to a Norwegian doctor they are very good too, but I think going to a Sri Lankan doctor is more comfortable when I am ill. I feel it easier to explain things and talk about other things too, I feel they understand me better; there are certain things that I feel are difficult to explain in Norwegian.

Another informant meant that at times of illness seeking treatment from a doctor with a similar background helps in facilitating the healing process. A Sri Lankan doctor is meant to understand one's life condition much better where treatment is proportional to what one's body has got used to:

I have a Norwegian doctor, as I came I met him so I continue with him, but if it is a Sri Lankan doctor some times things are different, because he knows my condition, the birth, there is a certain amount of truth in the birth. I will give you an example; once I went to Mecca and I became sick, they gave all the best medicines possible, antibiotics and all that, for two weeks I could not hear. Finally one doctor from Kashmir treated me and said that everything is alright. Then I met a Sri Lankan doctor who had heard about me, he came to my room, held me and told me: "Look here I brought some medicine but it is all over, I will write this buy it".

Now he knows my birth condition so he was able to give me a medicine that suited my needs, neither more or less. A Norwegian doctor thinks according to Norwegian levels, my body is completely differently made it has a different build up so if it is a Sri Lankan doctor he will treat me according to the Sri Lankan way and Sri Lankan build up. What they do in Sri Lanka when they treat you is they use a lot of antibiotics, so here I need a higher dose of antibiotics, because I am used to it from Sri Lanka.

Using traditional cures. The use of traditional remedies were meant and practiced to stay healthy. Traditional cures were used by some informants to treat themselves and their families in times of mild illnesses or when western medicines did not seem to work.

One informant had the belief that ayurvedic treatment had cured his eldest child from an allergic ailment. He says that his younger child suffers from the same condition as well, but the unavailability of these remedies over here puts his trust in western treatment even though the treatment had not helped to cure his older son earlier:

I believe for some sicknesses ayurvedic medicines help. In my family I had an incident where one of my children suffered some allergic problems we tried many western treatments that did not help. But after he got some ayurvedic medicines he grew out of it. Another of my children suffers from the same conditions but we do not have the opportunity to heal him over here, we have to trust on western medicines.

Another informant meant that she used home based remedies such as lime, coffee, and herbal tea at times of minor illnesses such as stomach aches and diarrhoea, coriander tea with herbs against coughs and colds and king coconut oil when applied was supposed to maintain the colour of her hair or cure headaches. She also used herbal balms against pain and aches:

Quite often a little lime and black coffee mixed and taken for a diarrhoea or stomach ache helps. Coriander tea with herbs for a cough or cold, king coconut oil for your head keeps your hair stay black and its cooling especially when you have a headache. I also use herbal balms against pains and aches. But the problem is that these things are not always available over here.

One informant said he has a cup of plain hot tea after a heavy meal meaning that it helps to digest fatty foods:

I generally drink a cup of hot plain tea after a heavy meal, especially a fatty meal it helps to digest the fat. We eat a lot of vegetarian food but most of is prepared with margarine and coconut oil which contains a certain amount of fat.

Another informant meant that he does not drink tea and coffee but just drinks milk and hot water or hot water with ginger so as to purify his bowels:

I don't take coffee and tea, I drink milk, and I take two cups one in the morning and one in the evening. I drink a lot of water, hot water with ginger if I can. If I can I put some ginger because that purifies your internal intestines like that, so I take that, and that keeps me ok.

Another informant said that unpolished or red rice was both nutritious and healthy and his family ate it quite often. He considered him self healthy due to what he ate, drank, and did:

We eat a lot of red rice or rather unpolished rice. Red rice is supposed to be very nutritious and healthy. Well I am close upon seventy years and consider my self quite healthy, so I assume that what I eat, drink and do seem to be working. Of course I do have my small ups and downs, but then every body has those.

The same informant meant that when ever available he prefers herbal forms of treatment to western treatment in order to maintain good health. He claims that he has faith and believes in ayurvedic medicine. His belief was that western medicines did have quite a lot of side effects compared to herbal medicines even though the process of treatment is lengthy:

When ever possible I use herbal treatments, if there is a choice between western treatment and herbal treatment. Western medicines have many side effects, where as herbal medicines you don't have a side effect. Herbal medicines either cure or it doesn't cure you. It doesn't create any other disease connected with that, so there fore I go for it and I do go for it. So health wise I would say I have faith in the ayurvedic form

of treatment. But it takes a longer time and you have to go through so many processes, but the advantages are greater on the long run.

5.5 Spiritual and philosophical dimensions of staying healthy

Themes of spirituality, religious practices and philosophical reasoning often appeared in their conversations and were considered important dimensions to staying healthy.

Maintaining spiritual and supernatural beliefs, how one lives and behaves and meditation were associated in their meanings and practices of staying healthy.

5.5.1 Maintaining spiritual and supernatural beliefs

Connection was made to the use of prayer and the trust in God and Supernatural powers in keeping healthy.

One informant said: *“I pray to my Gods to keep healthy, and go to the temple at least once a week. If not I pray at home.”*

Another informant meant that God plays an important part in his life in keeping healthy. He meant that there are many incidents that he believes that his faith in God helps him to lead a healthy life. One incident he was keen to mention was his experience of deportation and the trust in God. He believes that his faith saved him from deportation and the continuation of leading a healthy life:

God gives me the strength in my daily life, and there are many incidents in my life that I could relate to my faith in God. One important incident is just a few years back when I was refused an extension of my visa in Norway. The authorities meant that I had no ground to continue living here since I come from the western province of Sri Lanka which was not directly affected by the war. I even engaged a lawyer to fight my case, but that too failed. One day after I returned from work I got a message left by the police to meet up at the police station. Arriving at the station I was given a letter informing me that I was being deported. I was allowed to collect a few of my personal items and was followed down to the international air port at Fornebu awaiting deportation. That was the worst experience in my life and I was greatly depressed. I had lived here for some time but had not used my time constructively. I mean no savings and nothing to go back to. I was too ashamed to go back home. I just prayed and prayed. God answered my prayers, after a few days of waiting at Fornebu the authorities reversed their decision and I was allowed to stay. Today I have my permanent residency and in peace with my mind, thank God. I think it has a lot to do in staying healthy. Praying and going to church on Sundays is important to me too.

One respondent meant that he believes there is a God, a Supernatural power who could influence his health and he puts his trust in this supernatural power during times of sickness:

I pray every day and I believe in God, I believe that there is a supernatural power. I don't believe in all the religions, but I believe that there is a supernatural power. And my belief is that this power can influence my health. Some times I get fear into me when I get sick, then I put my trust in that belief.

5.5.2 Staying healthy is how we live and behave

The meaning of staying healthy was both directly and indirectly associated to the manner how one lived and behaved.

How we live and behave. One informant explained that even though some may think that ill health may be a punishment from God he had his doubts. He meant that the way we live and behave has a great influence on ones health:

Even though I grew up in a Hindu family I don't have strong beliefs any more, I very rarely go to the temple. Some people may think that God may punish you for that and cause sickness, but I don't think so, it has quite a lot to say how we live and behave.

Living in Harmony with nature. One informant meant that he believed in nature, and living in harmony with nature was meant to keep one healthy rather than being a punishment from God:

I believe living in harmony with nature keeps me healthy. Every religion says that god has created, so I am sure he would not destroy what he has created even though some may think that bad health or natural - disasters is a punishment from god.

5.5.3 Meditating

The respondent who practised yoga and meditation to keep him self occupied also meant that in addition to his main religion of Islam meditating lifts him up spiritually to a higher level giving him happiness. Happiness meant good health to him. But whenever there is a conflict between Islam and meditation he seeks guidance from his religion as it is guidance from a Supernatural power. But he stressed the point that meditation played an important part in his life improving his health to a great extent as well as his wealth:

When I meditate spiritually I am on a higher level, I don't claim to be but I am supposed to go to a higher level, where you consider the whole world as yours and try to without religious bias and consider human beings as human beings and help them where ever you can, irrespective of their religion, the people are people and the needs are the same whether one is a Buddhist, Muslim or something else, this gives me happiness and happiness means good health to me. But you see as I am a practising Muslim too, I do every thing what Islam says, some people don't agree and some do, practically I find it ok, but when ever there is a conflict between my religion and my meditation I take the side of the religion in seeking guidance as it comes from a Supernatural power. But any way I would say that meditation plays a very important part of my life, it has improved my health tremendously as well as my finances.

5.6 Political and legal factors

The political situation in Sri Lanka reflected very often in the informants conversations and they longed for their former way of being to stay healthy. Having a proper job and not being discriminated in Norway as well were associated in staying healthy.

5.6.1 Following developments back home and longing for the former way of being

All informants had one thing in common; they had left due to the political unrest and ethnic conflict in the country. Though their physical health may be intact, their reflections describe mental agony. Due to the conflict and resulting deterioration and destruction of the infrastructure of Sri Lanka, those who preferred to return and spend the rest of their life in Sri Lanka like before were forced to change their minds.

One informant meant that he lived in Norway mainly due to the political situation in Sri Lanka. He was happy to live here but called Sri Lanka home. He disliked the winter, missed the climate and does experience loneliness and depression at times longing for home. But then again he consoles him self by the fact that his children and grand children live here:

You know the reason for us being here, if our home country had a stable political environment we wouldn't have been here in the first place. Of course I am quite happy to live here, but definitely living in Sri Lanka where I grew up is home. I don't like winter, I miss the sunshine and climate and I do feel lonely and depressed at times longing for home, but any way I have my children and grand children and cannot grumble too much.

For another informant staying healthy meant going back home to Sri Lanka as he got older, but as it is not a reality due to the political situation and the infrastructure in Sri Lanka he has changed his mind and thinks it is better to live in Norway as he gets older:

Earlier I had the idea of going back when I got older, but that dream is far from reality as things are getting bad to worse, the other thing is for example is that if you have to go to the doctor or see a specialist you have to travel for five hours at least or it even ends up being a one day trip. Now I think maybe its better to live here as I get older.

Another meant that thinking about the future worried him. He meant that he stressed about the future too much. He would have preferred to travel down to Sri Lanka and live with relatives as he got older but the political situation keeps him away: *"The future is worrying, maybe I stress about it too much, I would like to have travelled down and preferred to live with relatives as I get older, but the political situation is such that I just cannot return"*.

Some had left a part of their wealth and belongings in the hands of relatives thinking that they could return one day as they got older. But as time goes by and the chances of returning becoming a distant, they feel cheated by their own relatives causing them mental distress and worry:

When we left the shores of Sri Lanka we gave our house to one of our relatives to look after thinking we could return one day, but now these people are refusing to move out. We are quite keen in selling the house but they expect us to give it to them for nothing, this keeps worrying me.

5.6.2 Having a proper job and not being discriminated

For those who still could work, having a proper job and not being discriminated were associated with staying healthy. Many of the informants expressed physical exhaustion and mental distress due to their type of working environments. Two of the three informants who were above retiring age did not work any more, whilst one yet kept him self employed. Two who were below retiring age meant they had to give up working due to physical ailments associated to their types of work. To were educated in other fields but had not been able to gain employment in their relative fields of work. Discrimination due to being from another culture and age were mentioned as barriers in getting employment. Many negative factors were associated as to being unemployed. Mental stress, financial difficulties, family disputes, social stigma among society, loss of respect and unexplainable physical and mental ailments were mentioned.

One informant said that he was advised to get another job by his physician as his type of work had affected his spine. Following his physicians advice he had tried to get another job but failed. He thought one reason could be his age but had not given up trying. He meant that he experiences mental distress, financial difficulties, stress and even thinks that he makes life uncomfortable for his family as well:

I was advised by my doctor to get another type of job, I was working 17-18 years in one place and that affected my back. I followed his advice but found it difficult finding another job, it is very difficult now to get work at my age but I am trying. I feel that in fact mentally I am not so happy and feel sick at times after I stopped working. I have less money in my hand, I get frustrated and stressed much easier than before and make life uncomfortable for my family too.

The same informant said that due to being unemployed he avoids social gatherings as it makes him uncomfortable when people question him about work. He felt that he was less respected and it was a social stigma not to have a job in his society.

I do not attain many social gatherings unless it is very necessary, as I don't feel comfortable when people ask me about work, well you know in the society I represent it is a social stigma not to have a job. People don't respect you.

Health is considered the possibility of being employed and not feeling rejected or discriminated in the job market. For one informant job rejection was considered as to being a foreigner, a Muslim or due to old age:

Things should improve for the foreigners; in some cases people don't get jobs. To date I have sent in 1300 applications but just been for two interviews, maybe because I am a foreigner, second is I am a Muslim and of course may be my age.

Another informant mentioned the feeling of being a foreigner and old age could be the reason as to why he could not get employment in the field that he was educated. This gave him mental distress:

I could not get a job in the field I am educated in which gives me a lot of worries. I am employed now but not in the same field, it was not easy to get jobs for foreigners, the language was not a barrier, but may be being a foreigner, the experience and age could have been a barrier.

5.7 Technological factors

Having internet access and mobile phones were meant and perceived to keep one healthy by the elderly Sri Lankans who used them.

5.7.1 Having access to the internet means staying healthy

With the use of internet one of the eldest of the informants kept him self occupied with studies and news updates. Being occupied meant to keep him healthy. Another informant learnt more about illnesses that he, his family or friends were diagnosed with and exchanged this knowledge with his friends.

One of the eldest of the informants who was following a correspondence course referred to the use of internet, of how it kept him in touch with his lectures, helped him to follow news from Sri Lanka and in the meantime also kept him occupied. He was quite keen in keeping him self occupied at an old age to keep healthy, and mentioned that internet helped him do so:

You know as I said earlier I am doing some studies at the moment, correspondence studies, and the internet helps me keep in touch with my lectures and keep my self busy. I also manage to read about what is happening at home. Studying and reading helps me to keep my self occupied, which I consider to be good for my health.

Another informant meant that when he needs further health related information as getting to understand illnesses he, his family or friends have been diagnosed with, he often uses the internet. He also used the internet to exchange this information with his friends:

Some times when I got to the doctor and he mentions that I have a certain illness at the moment, I go back and try to get more information from the internet. You don't always understand what the doctor says and this helps me understand things better. Not only reading about my ailments, but I also try to help my family and friends to get more information about their illnesses.

5.7.3 Maintaining mobile phone communication with ones family

Maintaining mobile phone communication with ones family prevented isolation and gave a sense of security at times of illness to an informant who used it.

The informant said that having a mobile phone gave her a feeling of not being isolated, and it also helped her to keep in contact with her spouse and children, especially at times of emergency or illness: *"I don't feel alone having a mobile phone, it also helps me to get in touch with my husband and children when ever I need them, especially when I don't feel well."*

6.0. DISCUSSION

6.1 Economic means and health

Maintaining economic success was an important aspect in staying healthy for an elderly Sri Lankan. Achieving and maintaining economic success for health and well being have also been reported by Ahamed and Lemkau (2000) on studies done on South Asians including Sri Lankans in the United States. The elderly, their children and grand children being economically successful were meant to secure a healthy lifestyle. This view is supported by statistics on immigrants in Norway as well, where it shows that Sri Lankans have a high employment rate in comparison to most other non western immigrant groups (Lie, 2004). Broken down by nationality among non-western immigrant groups 66 % of Sri Lankans were employed, second only to immigrants from Chile 68 % (SSB, 2007).

High employment rates, restriction of welfare facilities and socio-economic dependence on the family may be some of many reasons as to why Sri Lankans who had arrived in Norway between the periods 1987-1988 had also accepted or received the least amount of social help compared to immigrants from other third world countries (Vassenden, 1997).

However, though the employment rate is shown to be high among Sri Lankans, some of the elderly in this study with working ability had experienced difficulty in gaining employment or receiving financial support. Unemployment and lack of adequate wealth was meant to cause stress, ill health and displeasure amongst family members, especially one's spouse and children. Association between unemployment, income and psychological distress has been shown in earlier studies among immigrants as well (Pernice and Brook, 1996; Wiking, Johansson, Sundquist, 2004). A stress factor also discussed by Helman (2000) under the cultural aspects of stress is economic status. Unemployment, deprivation and poverty associated with poor housing and diet are supposed to be potent stresses to any community as well as the loss of income and financial insecurity.

Some informants experienced stigmatisation by their own communities for being unemployed as found in section 5.6 of this paper. Receiving social-aid was perceived to be humiliating, shameful and unacceptable. Unemployment and lack of income strongly influences the socioeconomic status and mental health in immigration populations was shown in a study by Wiking, Johansson and Sundquist (2004). Unlike for the elderly Norwegians, the families of elderly Sri Lankans were expected to step in with socioeconomic assistance when required. Economic and housing support from successful children contributed to the notion of maintaining economic success and good health among

the elderly Sri Lankans. Ahamed and Lemkau (2000) report similar findings among South Asians immigrants living in the United States including Sri Lankans. While maintaining economic success could be a similarity to the Norwegian and other Scandinavian societies, receiving socioeconomic support from their offspring could be seen as diversity from the majority culture but similar to other South Asian cultures. In Moen's (2002) study individualism and independence were said to be given prominence by the elderly Danes like the Norwegians. They Danes too had considered the family to mean a lot to them but were not totally dependent on the family for their well being unlike the Pakistani elderly. Depending on their immigrant status, some elderly informants were forced to continue working as well and exert socioeconomic dependents on their families due to restrictions of the welfare facilities available to them causing distress. To qualify for social benefits the same rules and laws are said to apply to the native Norwegians and immigrants with non refugee status (Hansen, 1998; Moen, 1993). Conditions to be met to have the right to receive a maximum pension at retirement, is that the individual has to be member of the state pension scheme for at least a period of 40 years. Like Moen (1993) points out in her studies on other major immigrant groups, most Sri Lankan immigrants too have a shorter working life and membership of the state pension scheme thus resulting in a reduced payment compared to a native worker causing stress, distress and dependence. For immigrants having refugee status or for those who have been granted political asylum settlement or stay periods do not apply to be granted or qualify for a maximum basic pension or social help. As in Moen's (1993) study of other non western immigrant groups, parents of Sri Lankans arriving at an elderly age do not qualify to receive a state pension if they had arrive in the country once passed the age of 65. A condition demanded for family reunion is that the family in Norway complies with an economic guarantee that covers the expenditure of arriving parents or relatives (Hansen, 1998). Thus the children are compelled to step in anyway for those who don't qualify for welfare benefits to stay healthy. This is in contrast to the Norwegian elderly who are dependant on the state welfare and health services for their health and well being. How long an elderly Sri Lankan immigrant could be self supportive, or depend on one's family to stay or remain healthy is a big question. Family supported home care to maintain their health and wellbeing is said to function for some of the immigrants but not for all (Dawes and Thoner, 1997), and some Sri Lankan elderly immigrants too immaterial of their immigrant status would have to depend on the state welfare services at one time or another to have an adequate income for their daily expenses in order to stay or remain healthy. Reduced mental health in migrants

over the age of 60 has been shown to be related to disadvantages in access to health and social services in England (Littlewood and Lipsedge 1997; Silveria and Ebrahim 1998).

Whilst having to financially support them selves in order to maintain health and well being, assisting family and relatives in need in Sri Lanka are an additional financial strain that some elderly Sri Lankans face unlike the Norwegian elderly. But even though it is an additional expense to help those in need, helping is considered to give them health and happiness. Helping was also meant to be a duty. Moen (1993, 2002) in her studies also shows that immigrants supported their needy relatives in their home country. In contrast to developed countries such as in Norway the health and well being of the elderly, handicapped and the poor in Sri Lanka depends on finances and care provided by family, friends, a few non governmental organisations and religious institutions (Abeykoon, 2002). Much is demanded from those living and working abroad. Therefore helping close relatives and causes in Sri Lanka is considered a social responsibility even at an elderly age as there is no proper state responsibility towards the elderly (Martin, 1990; Abeyakoon, 2002). Helping those in need is considered to give an elderly Sri Lankan health and happiness, however not being in a position to provide or finance those in need meant to cause mental agony and distress and feeling of helplessness for some. It is an ethical dilemma faced by some of the Sri Lankan elderly in Norway who already experience financial difficulties to be expected to provide for friends and relatives in need in Sri Lanka. Although not only from the elderly, according to Carling (2005) 1100 million US\$ had been remitted to Sri Lanka in 2002. This had listed Sri Lanka as one of the top 25 remittance receiving countries in the world in the year 2002. The exact amount remitted from Norway to Sri Lanka is not known, but Carling (2004) mentions that more than 60 % adult immigrants from Sri Lanka and approximately 40 % young immigrants who had come as children from Sri Lanka had remitted money in 1996. Although these remittances may have many causes, they are mainly seen as family support remittances. Many of the people of the conflict affected areas would not survive without remittances claims Van Hear, Pieke and Vertovec (2004).

In situations of care, the Norwegian Nurse should pay special attention to the elderly Sri Lankans cultural values, beliefs and practices in association to their health and economy. The nurse should be able to identify a cultural similarity to the Norwegian society where maintaining economic success is valued, meant and practiced in an attempt to maintain health and well being at an old age. Although these goals are achieved in some what contrasting ways, a deep understanding of the cultural and political reasons behind for their

actions are necessary in order to offer cultural congruent care. However, whilst trying to respect and maintain the cultural values, beliefs and practices of the Sri Lankan elderly and their families in the type of socioeconomic support practiced in order to remain or stay healthy, the nurse at times might have to intervene by what Leininger (2001), Leininger and McFarland (2006) mean by Culture care restructuring in order to help the client and their families who face economic hardships. The clients and their families should be convinced that the elderly do not have to be ashamed, push themselves to work, undergo stress and experience family misunderstandings due to their financial difficulties they face. All information on elderly rights, health, social and welfare benefits available should be made known to the client and their families. The elderly should be convinced to accept the welfare help available at times of need in order to stay or remain healthy when ever possible.

If the helping of those in need in Sri Lanka means or maintains the health and happiness of the elderly Sri Lankan, the Norwegian nurse should look for opportunities to help the elderly continue this practice in situations of care. Culture care preservation and or maintenance (Leininger, 2001) should be encouraged depending on the resources available. The families and relatives should be consulted and assurances should be given to the elderly that their practices would be maintained. In case there is disagreement among the families or for those who don't have families, legal appointees arranged by the county should be arranged to handle the client's finances if the client is not in a position to take care of his or her own finances. If the nurse experiences that the economic situation of the client is such that the practice of helping those in needs in Sri Lanka may not be possible, an alternative practice should be negotiated and accommodated when ever possible. However, it is important that the nurse makes a genuine attempt to fulfil the client's beliefs and practices as long as it is possible, because it is a cultural practice that keeps the client in a state of psychological well being.

6.2 Education

Like economic success, achieving educational success too is of vital interest to the Sri Lankan elderly to maintain their health and well being. All the informants had arrived to Norway in the 1980's and could be considered as the second wave of immigrants from Sri Lanka (chapter three). Except for two of the subjects who had arrived on the grounds of family reunion at an elderly age and had university educations from before, the rest of the informants had all managed to educate them selves further in Norway even though arriving

as adults. All the informants had primary and secondary educations from before but were compelled to complete obligatory subjects to continue studies in Norway. Five of the informants had completed the secondary education they lacked and four out of these five had gone on to complete skilled trades. None of the informants had managed to get jobs that suited their trades but had still managed to get employment in other service sectors. All the informants including the eldest out of the lot had completed at least a year of a Norwegian language course.

Whilst most have educated themselves to secure a healthy live hood for them and their families both here and in Sri Lanka, those beyond their active working ages continue to educate them selves to keep them selves occupied as well as brighten their wisdom. Except one of the informant's who did not have children, the rest meant that they have devoted a great amount of time and sacrificed other luxuries in an attempt to educate their children. It is assumed that by educating and securing their children's future, also guarantees them a safe and secure old age giving them health wealth and happiness. Whilst some are already taken good care of their well established children, the others assume that their children yet under education would take care of them giving them joy and happiness at an old age.

The drive to succeed educationally has also been reported in other studies (Fuglerud, 1997) on the Tamil speaking community in Norway and Ahmed and Lemkau (2000) about Asians including Sri Lankans living in the United States. Ahmed and Lemkau (2000) say that succeeding educationally and financially is said to be of paramount importance where some times younger immigrants are said to frequently experience pressure from their extended families to achieve further educational goals and economic success. Anticipated financial responsibility for both their nuclear and extended families are reported similar to this study.

This paper as well the above mentioned studies reveal that in contrast to earlier findings of non western immigrants in Norway (Blom and Ram, 1998), Sri Lankans are a quite well educated immigrant group quite similar to the Norwegians or other western immigrant groups who depend on a good education for their health and well being. Helman (2000) says that people who are educated and successful with economic control over there own lives, accepted greater responsibility for the causes of ill health than those who viewed themselves as socially economically helpless. Some studies show that old age and lack of education are generally acknowledged as risk factors for mental distress among immigrants (Pernice and Brook 1996; Thapa and Hauff , 2005). As highlighted in chapter three, Blom

and Ram (1998) had carried out a study in 1996 on the living conditions among immigrants based on their education, work, economy, dwelling, social contacts, health, discrimination and other activities. Eight different minority backgrounds were represented within the age group of 16-70 years. In contrast to the findings in this paper their rapport shows that non western immigrants when compared to Norwegians have an average lower educational level and are exposed to greater hardships in their working lives than a Norwegian. However, similar to Blom and Ram's (1998) study, informants in this study had also experienced hardships in finding suitable employment and had taken up to alternative and physically strenuous jobs that in fact had effected their health.

Unlike most other developing or third world countries Sri Lanka has managed to maintain a high level of education amongst its people. The literacy rate of 94 % male and 87% female in 1995 (The world guide, 2001/2002), reflects the ability of how many could read and write. Having a high literacy rate from before could be assumed as to a reason why it maybe easier for many of the Sri Lankan's in Norway too to continue with some sort of education even at an elderly age. Statistics show (Vassenden, 1997) that Sri Lankan immigrants were second only to the Iranians when it came to higher education at high school or university levels compared with the rest of the third world countries.

In order to offer culture congruent care the nurse or health worker should be sensitive to most elderly Sri Lankan clients and their families' educational and occupational levels. The nurse should be able to recognize a universal similarity when compared to a Norwegian client in the standard of knowledge exhibited and the perception that education is important for an elderly Sri Lankans health and wellbeing. High educational standards have been experienced and set for themselves and their children where education is supposed to bring honor, prestige, wealth, happiness and a secure older life. It is important for the nurse to support and maintain these educational and intellectual achievements that facilitate their health and wellbeing in order to provide cultural congruent care. The knowledge of the elderly should be used as a resource when ever possible; their voices should be heard in the planning and implementation of care to the Sri Lankan elderly community in general. Those who want to actively participate and follow different educational programs should be encouraged to do so. Families too could be encouraged to continue being supportive of the elderly Sri Lankans to remain or stay healthy where their knowledge and participation should be used and accepted if beneficial for the clients. After all the families cultural knowledge, support and understanding of the elderly Sri Lankan is generally irreplaceable and should not be viewed as a disadvantage. This type of care could

referred to what Leininger (2001) means as cultural care preservation and maintenance, where the nurses actions focus on supporting, assisting, facilitating or enabling clients to preserve cultural values and life ways that is beneficial to the clients to retain favourable health, to recover from illness or to face even handicaps and death.

6.3 Kinship and family structure

Maintaining friends and family support among the Sri Lankan elderly was a dominant theme in their meanings and practices of staying healthy. Caring and being taken care of family and friends, meeting friends and sharing health related information, and returning home to relatives and friends dominate their meanings and practices of staying healthy. The only women in the study depended on socio-economic support from the family, while in the mean time she played a central role in the care, health and wellbeing of the rest of her family as well. Being taken care of the family and taking care of the family meant staying healthy to her.

Westerners are expected to see themselves as autonomous, independent, individual units with sharp boundaries between them selves and others (Helman, 2000). As a result in Norway too as in the rest of the western world an individualistic ideology (Slagsvold, 1999) is exhibited in relation to health and wellbeing, ageing and care for the elderly. The public health care services are well developed and the elderly in need of care for their health and well being do not have to depend on their family members or friends to be taken care of. In fact in 1964 Norway had passed an act that absolves children off financial and social responsibility for their parents Moen (2002). With this act it is expected that children should not need to devote their time, energy and recourses or burden them selves of caring for elderly parents who are in need of assistance. It is expected that an individual should be independent and manage on his or her own for as long as possible, when services are needed the public health care services are required to step in. The individual is also expected to a great extent to exhibit responsibility for his or her own health and wellbeing. This form of responsibility according to Moen (2002) could be referred to as individual orientated elderly care.

In sharp contrast to the Norwegian elderly, the Sri Lankan elderly exhibit close interdependence within the family and friends for their health and well being. It is the family, above all other institutions that is given responsibility of looking after their elders. The care of older parents in Sri Lanka is considered a moral obligation of the children (Martin 1990; Andrews and Hennink 1992; Abeykoon 2002; Siddhisena 2005). These

family traditions are expected to be continued in Norway and dominate the elderly Sri Lankans meanings and practices in staying healthy. Similar practices have also been exhibited by other Asian cultures studied both locally and internationally (Baluyot, 1999; Dawes & Thoner, 1997; Jan & Smith 1998; Leininger 1995; Moen, 1993, 2002).

The informants of this study who have extended families live either together or in close proximity to each other readily available to extend care and help when needed. At times of sickness and need it is considered important to have family and friends around them. Weerasuriya and Jayasinghe (2005) in their studies on elderly Sri Lankans above 65 had found out that those living with their children or spouse were significantly less depressed and in better health than those who lived without them. Similar findings have also been reported on elderly immigrants living in Sweden (Silveira, Skoog, Sundh, Allebeck and Steen, 2002).

A way of maintaining good health among the study participants was also discussing sicknesses, ailments and treatment given to them by the doctor and health centres with friends and relatives. Information is also exchanged about the available health services and specialist from where one could get advice in times of illness and need. Cultural gatherings were one way of doing so. These festivals bring family and friends together, give one the opportunity to make traditional food, and discuss events going on in Sri Lanka as well as discuss one's ailments and treatment which helps in the maintaining of good health. Social interaction in order to facilitate health and well being among Sri Lankan elders has also been reported in other studies (Siddhisena 2005, and Weerasuriya and Jayasinghe 2005). Dawes and Thoner (1997) have reported similar findings practiced by elderly immigrants from Pakistan and India living in Oslo.

The elderly who do not have children or close families exhibit a bit of uncertainty as to whether they wanted the community services to care of them as they get older and even express the idea of returning to Sri Lanka to be taken care of by relatives to maintain their health and well being. Even though having children some do exhibit a doubt as to whether their children would take care of them as well when the need arises. Some say that they are caught between two cultures as the attitudes of their children were changing. The informants in Moen (1993) and Dawes and Thoner (1997) studies had also expected the family to provide care and support that they needed as they grew older, however, though the social contact within the family had been fairly good there were indications of changing social patterns among the younger generations who seemed to be less inclined to continue a three generation household as wished by the elderly. Thus the wishes to return

to their home countries were even greater for some immigrants in the above mentioned studies as well.

Some of the elderly in this study wished to travel often to Sri Lanka on vacation as well. Travelling on vacation to their home country was meant to be relaxing and essential to stay healthy whilst living in Norway. Moen (2002) views this phenomenon from a transnational perspective where it is meant to be the affinity to both their home country and Norway and where much contact and time is said to be spent with and in their home country. Pakistani elderly were shown to keep contact with their friends and relatives living in Pakistan. Traveling to Pakistan or home was considered to be essential for good health and a good old age for the informants in Moen's (2002) study as well.

In order to offer culture congruent care it is of prime importance that the Norwegian nurse recognises that there is a dominant universal difference between the Norwegian and Sri Lankan cultures in association to kinship and family structure. Unlike the Norwegian elderly who live an individualistic and independent life, the Sri Lankan elderly exhibit close interdependence within the family and friends to stay healthy or recover from illness. Like Geiger and Davidsar (2004) mention about East Indian cultures, the pursuit of individualism, which is so predominant in western cultures, may not be the accepted norm among Sri Lankan Elderly and their families as well. The sense of familial obligation to one's parents, extended family and close friends are very strong. A Norwegian nurse who does not recognise this prime difference will not be in a position to provide culture congruent care.

Where kinship and family traditions could be maintained in order to facilitate health and well being, such as family participation in situation of care and where the elderly too have the possibility of actively participating in their traditional roles like for e.g. taking care of the grandchildren, supporting family members and friends in need both in Norway and Sri Lanka or taking care of other elderly when ever possible should be encouraged. Thus, while easing the demand on the health services, a family tradition of care too could be maintained. This form of action could be referred to what Leininger (2001) means as cultural care preservation and maintenance, where the nurses actions focus on supporting, assisting, facilitating or enabling clients to preserve cultural values and life ways that is beneficial to the clients to retain favourable health to recover from illness or to face handicaps and death.

When ever the nurse or the health care services have the possibility to adapt the service to benefit the Sri Lankan elderly client, culture care accommodation (Leininger, 2001) could

be practiced. Here the nurse or health care professionals should create an effort to facilitate, enable, assist, or support actions which represent ways to negotiate with or adopt or adjust to the client's health care patterns for a beneficial or satisfying health outcome. For e.g. home health care services and long time care institutions in Norway should make an effort to adapt their services to accommodate elderly Sri Lankans families and friends participation when ever possible to care for their elderly parents, relatives or friends within their premises. Families and friends should have the possibility to continue being the main care providers for the elderly Sri Lankans to remain or stay healthy for a number of reasons. In addition to being a cultural tradition, like Tan Poo Chang (1992) points out there can be no substitute for what a family can provide for an elderly person such as familiarity of surroundings, love and emotional ties, and a sense of belonging and of feeling wanted that could facilitate health and well being. These factors are said to be very important for emotional security, especially during a period when one becomes increasingly dependent.

When ever cultural values and practices with regard to family participation cannot be maintained or met, for instance if the client either has a family that does not have the means to be supportive or where the client does not have a family at all to turn or return to, then the professionals focus should be on cultural care re-patterning or restructuring (Leininger, 2001). Here the nurse or health service is expected to assist, support, facilitate or enable professional actions and decisions according to Leininger (2001) that helps the client to change or modify their life ways to a new different and beneficial health care pattern. While changes are being encouraged the nurse is also supposed to try to respect the client's cultural values and beliefs. Here the nurse or health care service would have the challenging task of getting the elderly Sri Lankan client to adjust or modify to a new way of life. Like for e.g. accepting help from strangers other than family members to remain or stay healthy. As gradual adaptation and integration of the families into the Norwegian society takes place cultural care re patterning or restructuring may be unavoidable at times. As mentioned earlier many relatives too might not have the same network, time, means and resources to participate in care consequently requiring the community services to step in often. This service thus, may be best offered in a cultural congruent manner by the employment of nurses and health personnel with a similar cultural background or nurses and health personnel educated in trans-cultural care. If and when as a last resort nursing home care becomes necessary it will be very important for the nurse as recommended by McFarland in Leininger (2006), to recognise and help both the elders and their families to

understand that care in a nursing home does not indicate an abandonment of elders by their families, but rather a re-patterning in the way their families provide care for their elderly. However, the nurses must try their best to continue to accommodate the traditional care pattern of family care in the elders own homes as long as possible, as there can be no substitute for what a family or friend can provide for a Sri Lankan elderly immigrant in an alien land to stay healthy, recover from illness or even face handicaps and death.

Position of the women in the family. As for the female informant in the study, her spouse, children and grand children played an important role in keeping her healthy. The findings reveal that her family meant everything to her, where she gave priority to the health and well being of her husband children and grand children. She also stressed that she would have been quite lonely and helpless without her family around her. The informant unlike in Norwegian or other western cultures exhibits a total dependence on her husband and children for all out door activities and she in turn plays the role of an obedient housewife, maid, mother, grandmother and caretaker, seeing to the efficient running of the home front and the health and wellbeing of the rest of the family. The husband and children could be interpreted as to being the decision makers. Earlier studies done on other south Asian immigrants and relevant literature support this assumption of the woman's role in society (Basuray, 1997; Giger and Davidhizar, 2004; Moen, 1993, 2002). As presented earlier in chapter three, Moen (2002) too points out that amongst the Pakistani elderly some of the women's tasks were at home where they had no dealings with strangers whilst the men had had a greater flexibility to operate outside home. The men had the responsibility for contact and tasks in relation to the rest of the Norwegian or other societies.

Religion too could have an influence on the behaviour and authority of women in the Sri Lankan society. The elderly female informant of this study represented the Hindu community. Hindu women are supposed to be ranked far below men in social status (Basuray, 1997). Marriage according to the Hindu custom is said to be a must because the unmarried woman is believed to have no place in heaven. Traditionally Hindus are said to hold their belief that the role of the woman is faithfulness and servility to her husband. Based on earlier customs the wife is also supposed to have few legal rights and was not able to publicly contradict or challenge her husband (Warshaw, 1988 in Giger and Davidhizar 2004).

The position of the Sri Lankan Elderly Hindu women's role in the family seems to be a cultural practice that facilitates a health out come. Thus in situations of care the Norwegian

nurse may find them selves facing an ethical dilemma where they may have to accept unlike in the Norwegian or western culture especially for this particular generation of Elderly Sri Lankans that the husband or man is regarded as the head of the family and maybe the primary spokesman concerning the health care of the other members in the family including the wife. Then the main aim of the nurse would be to try to practice cultural care preservation and maintenance (Leininger, 2001). The nurse should try her best to accept traditions and not try to change the husband's way of thinking at first but try to maintain and build a good professional relationship with the husband in order to help with the health care needs of the client. Cultural care accommodation and negotiation (Leininger, 2001) could be the next step where the professional or the nurse should create an effort to facilitate, enable, assist, or support actions which represent ways to negotiate with or adopt or adjust to the client's health care patterns for a beneficial or satisfying health out come without offending other members of the family. While trying best not to interfere with the traditions it is also important for the nurse to discuss with other relevant professionals of any doubts that may arise in the mind of the nurse that would result in a beneficial out come of the health and well being of the client. Cultural care re-patterning or restructuring Leininger (2001) may be necessary at times, where the nurse or health service is expected to assist support, facilitate or enable professional actions and decisions according to Leininger (2001) that may helps the client or families to change or modify their life ways to a new, different and beneficial health care pattern.

Family structure and organisation, role and role assignment are also discussed by Giger and Davidhizar (2004). They mean that when nurses provide care to clients from a social cultural background other than their own, that they must have awareness and sensitivity to the knowledge of family structure, organisation and role assignment in addition to many other factors. Therefore in situations of care with Sri Lankan elderly clients it is important that the nurse has a prior theoretical knowledge of these different family structures and roles such as the woman's or wife's role that is beneficial for the families and clients health and well being. Friedman (1986) in Giger and Davidhizar (2004) argues that nursing care should be directed to the family as a whole as well as to the individual family member. It is advised to look at the family as having two separate entities, one being the family as an environment and the other being the family as the client. Both approaches to client care is said to be useful when the nurse tries to provide culturally congruent nursing care. When viewing the family as the environment it is advised that the primary focus of care should be the health and development of individual family members within a specific environment.

In this situation it said to be important for the nurse to find out the degree to which the family provides the individual basic needs of each person. Here too it is stressed that the fact that families provide more than just the physical needs where the ability of the family to help the client meet psycho-sociological needs is enormous. When family members are viewed as clients, the nurse is advised to access crucial factors that are relevant to family structure and organisation. Whether the family is viewed as an environment or as a client, Giger and Davidhizar (2004) too mean that it is important to incorporate cultural concepts when the nursing care plans are developed in order to provide cultural congruent care.

6.4 Spiritual, philosophical dimensions, cultural values, beliefs and life ways of staying healthy

The seven Sri Lankan Elders in this study represented three different major religious groups, namely the Hindus, Catholics and Muslims. This diversity is quite unique to the Sri Lankan society and not easily found among the native Norwegians and other major immigrant groups. Associated themes of spirituality, religious practices and philosophical reasoning often appeared in their conversations and were considered important dimensions in staying healthy.

6.4.1. Maintaining spiritual and supernatural beliefs

In addition to the Western belief by some who meant that illness was brought about by the way we live and behave, others immaterial of being a Hindu, Muslim or Catholic believed that there is either a God, or a Supernatural power that could influence their health as well. At times of illness or distress, connection was also made to the use of prayer and the trust in God or Supernatural powers for recovery in addition to seeking help from folk and western medical systems. The belief that a supernatural power or God could influence one's health has also been reported in studies on other ethnic groups both locally and internationally (Ahmed & Lemkau, 2000; Higgins & Learn, 1999; Jan & Smith, 1998; Moen, 2002; Papadopoulos, 1999). Illness and cures believed to be influenced by the supernatural world is among the explanations also referred to by Helman (2000) in his lay theories of illness causations. Here as explained in chapter two, illness is ascribed to the direct actions of supernatural entities and cure is aided by prayer. In studies carried out in the United States among Indian Hindus (Giger and Davidhizar, 2004), religious shrines were said to be prevalent within many house holds and were located in various parts of their homes. Each family is said to have a set of specific Gods and Goddesses to whom

they pray to for their health and well being. Hindus are said to have many Gods and Goddesses. The shrines had contained statues and pictures of the chosen Gods where candles, incense, and offerings of milk, flowers and fruits had been placed.

6.4.2. How We Live and Behave

The informants beliefs of health or illness being influenced by the way people live and behave could be due to both Hinduism as well as their adaptation to a western lifestyle.

A belief in Hinduism too according to Giger and Davidhizar (2004) is that Brahma is the principle and source of the universe and the centre from which all things are said to proceed and to which all things return. Reincarnation is also a central belief where life is determined by the law of Karma, which states that rebirth is dependant on moral behaviour in ones previous stage of life or existences. Life on earth according Hinduism is transient and a burden. The goal of existence is meant to be liberation from the cycle of rebirth and re-death and entrance into nirvana, which is a state of extinction of personal desire and passion. Some Hindus are said to believe that because man is a combination of good and evil, there is a need for constant control and discipline of the self if any real goodness or an healthy life style is to be achieved (Giger and Davidhizar 2004).

Living in harmony with nature was expressed by one of the subjects as his meaning and practice of staying healthy. This meaning of staying healthy could be associated to his Hindu background as well, where according to Kluckholn and Strodtbeck (1961) in Giger and Davidhizar (2004), explain that Hindus, believe in the man-to-nature orientation where man is not only subjected to nature but also has a need to live in harmony with nature. Hindus are perceived as being past, present and future orientated and are said to subscribe to a multiple man to nature orientation.

A lay theory that also corresponds with the view that one's health being determined by the way we live and behave is the theory where the origin of ill health is placed within the Individual (Helman, 2000). As presented in chapter two of this paper Helman (2000) explains that here the responsibility for illness falls mainly although not completely on the patients themselves and is common in the western world. In Moen's (2002) study, like among the Norwegians, individualism is said to be given prominence by the elderly Danes too unlike the elderly Pakistanis living in Norway. Responsibility aimed at the individual of avoiding illness and promoting good health is said to be also encouraged by the state and community health education programmes Helman (2000). Ill health is said to occur due

to not taking care of ones diet, dress, hygiene, lifestyle, relationships, sexual behaviour, smoking and drinking habits and physical exercise and so on.

6.4.3. Religion and diet

Religion and diet were closely associated and played a central role in their meanings and practices in staying healthy among the informants. According to Helman (2000), food is more than just a source of nutrition, where in all human societies it is said to play many roles and is deeply embedded in the social, religious and economy aspects of every day life. Like for the Sri Lankan elderly, most immigrant groups are said to bring with them their own dietary culture or their traditional beliefs and practices relating to food that influences their health and wellbeing. Helman, (2000) agrees that food not only does ensure a sense of cultural continuity with their country of origin, but that it also plays many symbolic, religious and social roles in their daily lives. The Hindu informants in the study had various practices, except for one informant who was a strict vegetarian; some abstained from eating meat and fish at least once a week, and others ate meat and fish occasionally or when served out of their homes mainly not to displease their hosts. Hanssen (1998) also mentions that diet patterns vary very much among Hindus depending on accustoms to local norms, religious perspectives and hygienicall beliefs. In Hinduism Giger and Davidhizar (2004) mention that some times the common custom of fasting is observed on specific days of the week, depending on which God the individual worships. It said that this practice is predominant among the women of the family. Fasting rituals are said to vary from absolute abstinence to consuming only one meal a day. According to Hinduism one is forbidden to kill or eat any animal, particularly the cow which is considered holy. Milk and its products may be eaten, since they do not involve taking the animal's life. Fish and eggs are infrequently said to be eaten (Helman, 2000). Most of the elderly in the study meant eating vegetarian food or fish occasionally is also a necessity in maintaining good health in addition to being a religious practice. Some had even changed their eating habits after living in Norway for some time; vegetarians had started to eat meat but were careful not to over do it.

For the Muslim informant staying healthy meant having a clear religious conscience as to what one eats. Whilst eating Halal meat was considered important for his health, the practice of abstaining from certain foods, eating ecologically grown food, fresh vegetarian or fresh foods, lots of fruits and exercises on a regular basis was also considered important.

According to Helman (2000), in Islam neither pork nor any pig products are permitted to be eaten. The only meat permitted according to Islam that can be eaten is said to be that meat from cloven hoofed animals that chew the cud and it must be Halal or ritually slaughtered. Luna in Leininger (1995) describes Halal as things that are permissible or lawful according to the tenets of Islam. The code of Halal is said to apply when the animal is slaughtered with the use of a sharp knife to spare the animal of unnecessary pain, recitation of verses from the Koran and facing towards Mecca. Shell fish, shark and eels are also said to be forbidden too, and only fish that have fins and scales may be eaten.

6.4.4. Health maintaining beliefs and practices

Proper nutritional intake, going for regular checkups, seeking professional advice and treatment, adequate sleep, keeping one self occupied and having a positive mental attitude, yoga and meditation, exercise and sports, and avoiding stressful situations were meant and practiced. Seeking help from the western medical profession at times of sickness dominates their meanings and practices, but traditional remedies and alternative practices are used at times of mild illnesses or when Western medicines does not seem to cure their illnesses. Being understood and receiving the proper treatment when seeking professional medical advice was also meant to be important in staying healthy.

The significance of food. The significance of diet, proper nutritional intake and good eating habits were stressed immaterial of religion to stay healthy.

Satisfaction and liking the food one ate was meant to be of importance for one's health. Therefore eating Sri Lankan food such as rice and curry was considered to be of immense importance to emotional satisfaction rather than being nutritious. Leininger (1995) mentions that food can make people feel physically better, psychologically good and have also many cultural and social functions. The findings in chapter 5.3 of this paper also shows that cultural festivals were looked forward to as way of maintaining good health by the elderly Sri Lankans. These festivals brought families and friends together, gave them the opportunity to make traditional food, and discuss events going on in Sri Lanka as well discuss ones ailments and treatments as well.

Informants were aware of the importance of proper nutritional intake and good eating habits. Some had even changed their eating habits after living in Norway for some time. Vegetarians had started to eat meat but were careful not to over do it. Similar health practices were reported by Higgins & Learn (1999) on Hispanic immigrants in the United States, the informants had been conscious as to what they ate.

Some studies have also shown that by trying to maintain traditional beliefs and practices relating to food, can result in occasional deficiencies and nutritional problems mainly to first generation immigrants rather than to their descendants born and raised in their host countries. Stroud in Helman (2000) has reviewed the commonest nutritional problems of other Southern Asian (India, Pakistan, and Bangladesh) immigrants in the UK. These included osteomalacia, rickets, and various forms of anaemia. Factors blamed for these nutritional problems amongst the Southern Asians include: a deficiency of vitamin D in the Asian vegetarian diet, the phytase content in the Asian diets which binds with calcium and prevents its absorption and skin pigmentation due to consequent reduction in vitamin D production. Even though not reported in this study, it may be likely some of the Sri Lankans too may face such deficiencies due to their diet.

Awareness, activity and rest. Going for regular checkups and seeking professional advice and treatment, adequate sleep, exercise and sports were meant and practiced by all the informants to stay healthy. This could probably be considered a cultural similarity or adaptation to the Norwegian society and the western world where the studies informants exhibit a practice of taking responsibility of their own health. This practice could be one again associated to the lay theory and the Individual world (Helman, 2000). Here the responsibility of taking care of one self, but although not completely fall on the people themselves. The belief is common in the western world where at times encouraged by respective governments' health education programmes, people are often made aware of how to live a healthy life style. In Higgins and Learns (1999) study of Hispanic immigrants as well in the United States, informants had perceived health in relation to their life style where diet, exercise and avoiding tobacco and tobacco smoke were mentioned. Informants had been aware of government promotion campaigns about healthy living.

Avoiding Stressful situations. Like for all cultures avoiding stressful situations were meant to be important for the Sri Lankan elderly to remain or stay healthy. Stress factors mentioned by the informants were, work and finances, neighbours and family members, deficiency of a family network and adjusting to a new way of life, worrying about the future, and developments back in Sri Lanka.

Association between unemployment, income and psychological distress has been shown in earlier studies among immigrants as well (Pernice and Brook, 1996; Wiking, Johansson and Sundquist, 2004) and has been discussed in section 6.1. Stress and illness has also been reported by Papadopoulos (1999) on her studies on Greek Cypriots Living in London as well. In her studies stress had been regarded as one of the primary causes of ill health. A

stress factor also discussed by Helman (2000) under the cultural aspects of stress is economic status. Unemployment as well as the loss of income and financial insecurity are said to cause stress which has already been discussed in section 6.1.

Migration alone from one culture to another is classified as a traumatic experience as well leading to stress (Ahmed & Lemkau 2000; De Veries, 2001; Helman, 2000). Migrants are said to experience isolation, helplessness and a feeling of insecurity in their new surroundings causing stress. Not only the leaving of family, friends and their familiar surroundings are stressful but they are often said to be faced with language difficulties and hostility of indifference from the host countries and new cultural practices that vary from their usual values beliefs and practices. This explanation could be easily associated to some of the informants in this study.

Meditation, being occupied and having a positive mental attitude. Yoga and meditation was practiced by one informant to keep him self active, occupied, and also lift him up spiritually to a higher level which was meant to give happiness. Being active, occupied and being happy was perceived to give good health. But whenever there was a conflict between his religion and meditation the informant sort guidance from his religion as it is guidance from a Supernatural power. But he stressed the point that meditation played an important part in his life improving his health to a great extent as well as his wealth. This informant comes from the North of Sri Lanka where the Majority of Hindus (UDI 1991/1992) reside. Therefore the practice of meditation may be attributed to the influence of Hinduism which is the majority religion of the area. According to Miller and Lass in Giger and Davidhizar (2004) many Hindus engage in meditation, yoga and prayer for their wellbeing. Looking for guidance from religion is said to be a common practice among Muslims as well. According Rahman (1989), Muslims commonly seek guidance from the Koran when needed.

Keeping one self occupied and maintaining a positive mental attitude was meant and practiced in staying healthy. Particularly one of the eldest of the informants in the study attributed the belief of being occupied as his main reason of maintaining good health. Another informant mentioned that after he had given up his job, he believed that his health deteriorated since he had nothing much to do. Similarly in Papadopoulus's (1999) study on the health and illness beliefs of Greek Cypriots living in London, some of the informants had expressed and believed that health very much depends on the individual's brain or mental attitude as well.

Being understood and receiving the proper treatment. Whilst for some it did not matter whether they received treatment from a Norwegian or Sri Lankan doctor, for others it did matter. However, the main issue was being understood and receiving the proper treatment as to remain or stay healthy. Going to a Sri Lankan doctor meant to give sense of comfort as it was easier to explain and talk about things in general as well. Certain things were also meant to be difficult to express and explain in Norwegian to a doctor of Norwegian origin. Ahmed and Lemkau (2000), Baluyot (1999), Dawes and Thoner (1997) and Hansen (1998) too, write that language barriers were some of the biggest problems that elderly immigrants face being patients. Even though they have much to say they encounter difficulties in expressing their feelings, wants, needs sicknesses and ailments even though they might have had much to say. Jan and Smith (1998) had experienced some informants in their studies as well wanting the services of doctors from the countries of their origin as they had meant that American doctors did not understand their culture and language. They also mentioned the difficulty of expressing their feelings and receiving the proper treatment.

Using Traditional Remedies. Even though western medicine is highly trusted, respected and used, the use of self treatment or treatment given by a relative with traditional remedies was yet practiced by some informants to treat them selves and their families. These types of alternative practices may rarely be seen among the Norwegian elderly. Ayurvedic treatment was meant to be trusted and some times preferred over western medicine or when western medicines failed. The uses of herbal medicine and alternative treatment forms among immigrants have been reported in other studies as well. Leininger (1995) among Asians in the USA, Higgins & Learn (1999) among Hispanics in the United States, Dawes & Thoner (1997) among Indian and Pakistani immigrants living in Oslo and Baluyot (1999). Abeykoon (2002) mentions that in Sri Lanka in addition to western medicine, Ayurvedic medicines are said to cater to a majority of people. Therefore it is not surprising that these alternative forms of medicine, beliefs and practices yet influence this studies generation of informants meanings and practices in staying healthy. The findings also correspond with what Klienman (1984) and Helman (2000) suggest that in looking at any complex society that one could be able to identify three overlapping and interconnected sectors of health care; the popular sector, the folk sector and professional sector. This study shows that all these three sectors of health care when ever possible are meant or practiced by most Sri Lankan elders' to maintain their health and well being. Finally the findings also corresponds with Leiningers (1995, 2001) assumption that

Generic (Folk or Lay) care systems that are culturally learned and transmitted to provide assistive, supportive or facilitative acts that improves health and wellbeing among different cultures exist among the Sri Lankan elderly too in order to stay or remain healthy.

Culture congruent care. The Sri Lankan elders' diverse religious, philosophical beliefs, cultural values and practices are of tremendous relevance for their health and wellbeing and should be given special attention and respect in situations of care. Leininger (2001) predicts that for care to be therapeutic and satisfying and to lead to health and wellbeing, it must fit the clients' religious and philosophical beliefs and cultural values, and life ways. As secondary data shows and although not involved in this study one should always keep in mind as a health worker that the probability of meeting a Sinhalese Buddhist client amongst the Sri Lankans living in Norway exists as well in addition to the religious and philosophical beliefs of the informants represented in this study. Giger and Davidhizar (2004) claim that it is of vital importance to seek information on the particulars of given clients to minimise negative stereotypes and act on false assumptions. Stereotyping is the assumption that all people in a similar cultural, racial, or ethnic group are alike and share the same values and beliefs (Giger and Davidhizar, 2004). Thus, in order to provide competent culture congruent care, the nurses needs to be aware of the world views of Christianity, Hinduism, Islam and may be Buddhism in situations of care to this group of elderly. An early identification of their religious and philosophical beliefs could easily aid in avoiding cultural conflicts and misunderstandings due to their vast differences and practices from the Norwegian nurse's culture and religious beliefs. For example the nurse must avoid concluding that all Sri Lankan elders she meets would be Hindus or in the case being a Hindu it does not mean to say that the client would be a vegetarian. Once religious and philosophical beliefs, values and practices have been identified the nurse should encourage and support the elderly to preserve or maintain these beliefs values and practices as long as they are not medically harmful. In case harmful practices are observed, the nurse should try to negotiate with the client to adopt or re-pattern their practices while still respecting their cultural values. Culture care re-patterning according to Leininger (2001) refers to altering health life patterns that are meaningful to clients while still respecting their cultural values. In order to offer culture congruent care, special attention should be given and arrangements made for the Sri Lankan elderly to practice and maintain their beliefs and activities that focus on prayer, religious rituals, and meditations both in their homes and institutions that benefit their health and well being. Special attention should be given and arrangements made for them to practice and maintain their activities that focus

on both diet associated to religion and diet according to their traditional food customs, both in their homes as well as in institutions that are beneficial to their health and well being. In case harmful diet practices are observed like for e.g. resulting in vitamin D deficiency (Stroud in Helman, 2000), the elderly Sri Lankan client should be encouraged by the nurse or health worker to supplement or adjust his or her diet to counteract the deficiency while still respecting their cultural values.

Like pointed out by Luna in Leininger (1995) on her studies on Arab Muslims, special attention should also be given to Sri Lankan diabetics a nurse may encounter in finding a balance between the need of insulin, fasting and their holistic health and well being. Even though not encountered in this study the nurse may easily encounter a similar situation. A devote Muslim or Hindu who has diabetes may find the sense of spiritual health and well being in fasting equally as important as maintaining a diet which balances his or her insulin requirement. In situations of care with a Muslim or Hindu client who has diabetes and who wishes to fast, the nurse could once again attempt to practice culture care restructuring (Leininger, 2001) in an effort to let the client practice his or her beliefs, but in the meantime restructuring ways to meet dietary and metabolic needs in order to prevent insulin imbalances and to maintain holistic health and well being of the client.

The nurse should also be aware of the similar cultural beliefs and practices in staying healthy an elderly Sri Lankan might share with a Norwegian elderly immaterial of the client's religious background in order to offer competent care. Independence and responsibility for their own actions that they mean are directly responsible for their health such as behaviour, proper diet and nutrition, avoiding stressful situations, being occupied and the necessity of training are some of the examples from this study. It is one of Leininger's many assumptions that there is some universality in human health care practices among cultures.

Western medicine is highly trusted, respected and used by elderly Sri Lankans to maintain their health and well-being, however, the use of self treatment or treatment given by relatives with traditional remedies are yet practiced by some informants to treat themselves and their families. Ayurvedic treatment was also used when western medicines were thought to have failed. Leininger (1995) assumes that Generic (Folk or Lay) care systems that are culturally learned and transmitted provide assistive, supportive or facilitative acts that improves health and wellbeing among different cultures. Thus the nurse should get to know about the elderly Sri Lankan immigrants alternative forms of care meant or practiced to maintain or improve their health and well being. Knowledge of these practices would

aid the nurse to offer care that is congruent with these cultural practices. Leininger (1995) theorised that knowledge of generic care practices could revolutionise nursing and health care practices if combined responsibly with professional care knowledge like nursing. The theorist prediction is that clients of diverse culture would show signs of faster recovery from illnesses experience less stress and conflicts with professional services and have a great potential to remain well when the best of both generic and professional care practices were integrated. It is also predicted that if these care practices are not effectively integrated, unfavourable client outcomes and the absence of culture congruent care would result.

6.5 Political & legal factors

The findings show that political and legal factors tend to influence the health and well being of elderly Sri Lankans living in Norway. Following developments Back Home and longing for the former way of being and having a proper job & not being discriminated were important aspects in staying healthy.

Unlike what a present day Norwegian elderly person may face, all seven informants had one thing in common, they had all left due to the political unrest and the ethnic conflict in the country. Though their physical health may be intact, their reflections describe mental agony and they longed for their former way of being to stay healthy. They also follow developments back in Sri Lanka as it seems to have a great impact on their present life and future plans. Most had left their homes, relatives, friends, jobs and belongings behind with the intention of returning one day to spend the rest of their lives back in Sri Lanka as they got older. Jan and Smith (1998) and Moen (2002) found that the subjects in their studies too had longed for the former way of being. Some had wished to return to their home countries on holidays and a few permanently as they got older similar to the Sri Lankan elderly. But it had been only a very few who had moved back as many had established homes and families in Norway too that were difficult to leave behind. This transitional adjustment was said to reduce the sense of loss and longing for home. Mental agony due to the conflict has been also sited in other studies concerning refugees and immigrants from Sri Lanka (De Vries, 2001). Earlier studies show that both pre and post immigration factors are considered risk factors for developing psychiatric illness, though migrants are generally believed to be healthier than their home population (Cantor-Graae, Pedersen, Mc Neil, and Mortensen, 2003). Enforced migration is said to cause loss of social, cultural and economic ties with ones country of origin increasing the chances of mental distress. Then

making the transition from a familiar culture to the culture of a new host country is said to also be emotionally challenging too. Major psychological dissonances are said to occur experiencing a new culture (Ahmed and Lemkau, 2000). The change is said to be even more challenging for older individuals where they are said to be unable to work due to language and cultural barriers. Post immigration factors are claimed to show association to mental distress too according (Helman, 2007). One of the many post-immigration factors highlighted is indifference experienced from the host population. In addition to the pre-immigration status they have been exposed to, a post immigration factor that affects the psychological well being of the informants in this study was meant to be job discrimination related to ethnicity and age. Some had not managed to gain employment in their suitable fields of education. As an alternative they had taken up lower paid strenuous jobs resulting in physical wastage, stress and depression. One informant experienced unemployment because he was unable to find suitable employment after giving up a difficult job that affected his physical health. This resulted in as he claims depression, financial difficulties and family quarrels. As referred to earlier the informants in Blom and Ram (1998) study too had also experienced hardships in finding suitable employment and had taken up to alternative and physically strenuous jobs that in fact had effected their health. Discrimination was mentioned as a possible reason. The view of discrimination in employment is also sighted in an article published in the *Aftenposten* on the 28 of April 2006. Under the heading Norway's immigrants well educated, it is claimed that even though Norway has one of the highest percentages of well educated immigrants in the world their inability to gain work could not be explained. An OECD (Organisation for Economic Cooperation & Development) statistics report had shown that four out of ten immigrants to Norway had received higher education but had faced problems in gaining suitable employment. The Norwegian Gender Equality and Discrimination commissioner Beate Gangås had been surprised by the figures and the then Minister of Labour and Social inclusion Bjarne Håkon Hansen had admitted that better results in employing immigrants were necessary. The OECD report had focused on Europe and the USA. Only Great Britain and Ireland were ahead of Norway in terms of highly educated immigrants. Some studies claim that social and cultural factors in exile among immigrants seem to exert a greater influence on mental health than exposure to violence before migration (Sundquist, Bayard-Butterfield, Johansson and Johansson, 2000). The clearest association is said to be shown between unemployment and psychological distress (Pernice and Brook, 1996).

The Norwegian nurse and health services have a challenging task in offering culture congruent care to Sri Lankan elderly immigrants to maintain their health and wellbeing associated with political and legal factors. Similar to earlier studies, both pre and post immigration factors seem to influence their emotional states. The informants who long for the former way of being have to be convinced to accept the fact that the hope of returning home may not be realistic at the moment. Culture care re-patterning Leininger (2001) may have to be attempted by the nurse where alternative health or life patterns that are meaningful to them would have to be sought after. While the Norwegian government attempted to bring a peaceful settlement to the conflict in the international front, other authorities at state level, county level and finally the nurses and other health personnel should try to create a place like home for these elderly immigrants. A place like home is irreplaceable but could be attempted substituted when ever possible. Higgins (1989) in Atkinson (1998) argues that, 'home' should remain a goal in residential care where the aim should be to provide as homely and home like setting as possible, with some semblance of a real home life to for the people who live there. But then again as Atkinson (1998) points out that a residential home can stimulate some aspects of home life but that it cannot be that 'real home' which offers sanctuary, space, occupation and identity. The author argues that any residential setting would require compromises since the client would be a member of a group and a very small part of the organisation. Quite often the needs of the group and the interest of the organisation is claimed to overshadow the needs of the individual.

The initial steps have been attempted at state level to try to create a homely atmosphere and provide culture congruent care to elderly immigrants in general. In the Parliamentary-statement (Stortingsmelding 50, 1996-97) "Action plan for elderly. Security-respect-quality" it is highlighted that the services should cater to all type of user groups or clients. When in need of care it is recommended that the provider of the services arrange for the possibility that elderly immigrants can live with others who speak their same language and have similar cultural backgrounds. It is also highlighted that an effort should be made mainly to encourage the home care services to cater to the needs of the elderly in their homes. Efforts being made to discourage employer discrimination also exist. The then minister of Labour and social inclusions admittance that better results in employing immigrants were necessary is encouraging. In a statement issued to the Norwegian state TV (NRK) the minister had mentioned that he had spoken to all directors of state companies and imposed measures and urged efforts to tackle the challenges linked to integration (Aftenposten, 2006). But the inclusion should also include elderly immigrants

who are yet capable of working. These are positive steps in the right direction in guiding a nurse or health worker to provide culture congruent care. Based on and encouraged by these guide lines, the state authorities, local authorities, nurse and health workers should make an effort to create a home atmosphere and discourage discrimination against these groups of immigrants when ever possible to maintain their health and well being. Either at home or an institution, a home atmosphere could be best created by meeting the needs of the Sri Lankan elderly to practice their cultural values and beliefs and life ways in a way that they would have practiced earlier. An atmosphere where they could, practice their respective religious & philosophical beliefs, be around with their families and friends, speak their own language, make and eat the food that they are used to in a manner that is comfortable for them, celebrate their cultural festivals, use their little home remedies, dress the way they like, watch the TV channels they prefer and even carry out their unsanitary tasks in a manner practiced by them. Elderly Sri Lankans of working age should be helped to find suitable employment, giving them the feeling of being wanted and not being discriminated. Although some actions might not be a direct nurse's task, the possibilities do exist to guide such clients to the respective authorities who could help them. When needed, counselling by professional counsellors with similar cultural backgrounds should be made accessible too. As De Vries (2001) points out it is important that counselling facilities are made available to those who need them with counsellors having the same cultural background being given preference.

6.6 Technological factors

Internet and mobile phones were meant and perceived to keep one healthy by the elderly Sri Lankans who used them. In this study the internet was used to keep informants occupied by being able to follow lectures from home, read news about Sri Lanka, gain health related knowledge and exchange information. The use of the mobile phone prevented isolation and gave a sense of security to the informants who used them.

A recently concluded study (Birvand Erdal, 2006), states that the internet with personal communications and visits home, seems to be the most significant source of information about home for the Tamil Diaspora in Norway. They are said to be able to communicate, within Norway, between different host countries and with relatives and friends in Sri Lanka. There are said to be many websites in English, Tamil and other European languages providing news and other information to Tamil immigrants of all ages.

Another study (Mickus and Luz, 2002) documents and supports the use of modern communication technology in helping to maintain long distance family relationships among elders and preventing isolation to a certain extent. In Mikus and Lus (2002) study low cost video phones were provided to elderly nursing homes residents and their families. The study demonstrated that videophones could be used successfully to enhance social interactions, regardless of distance.

As the internet and use of mobile phones were essential to maintain elderly Sri Lankans' health and satisfying life-ways, it is important that the authorities and the nurse to preserve and encourage these health maintaining practices either in their homes or long term care institutions. In the United States too (Browne, 2000), the population of elderly and the use of computers and the internet are both said to be growing at extraordinary rates in general, and the potential is said to exist for elderly to improve their own lives as well as well as the lives of others by making more use of this technology. Thus the key to increasing the number of elderly making proper use of technology are said to be by addressing both accessibility and usability.

The intense stress of transition into Norwegian culture is coupled with a massive disruption of the normal social patterns and the availability of extended family support for some elderly Sri Lankans. Internet and mobile phones may offset this disruption somewhat by giving the opportunity to communicate at any time in their own language and avoid isolation and feel close to home, their families and friends at quite a low cost. Thus supporting universal usability and accessibility of modern communication technology should be considered by the nurse or other health personnel when addressing care to elderly Sri Lankans immigrants either in their homes or long term care institutions. Thus culture care preservation and maintenance would be in effect and culture congruent care would be offered, aiding the elderly Sri Lankan immigrants to possibly remain healthy and function in their daily lives.

7. SUMMARY, RECOMMENDATIONS AND CONCLUSION

7.1 Summary

The Sri Lankan immigrants living in Norway too are beginning to age. They are growing old amongst strangers and little has been done to find out as to how they maintain their health and well-being away from their cultural origin. Therefore the discovery, description and analysis of their meanings and practices in staying healthy comprise the focus of this qualitative study which was conducted in 2005/2006. The aim is to obtain knowledge that could help nurses and the Norwegian health sector improve present day practices in providing culturally congruent nursing care to elderly Sri Lankan immigrants.

The theory of Culture Care Diversity and Universality developed by Leininger (1995, 2001) provided the theoretical framework for this study. The goal of the theory is to make nursing care decisions and actions that are culturally congruent with the beliefs, practices, and values of the life ways of the clients. The theory and study has a trans-cultural focus. With a trans-cultural focus according to Leininger (1995, 2001) and Leininger and McFarland (2006), nurses think about culture care differences (diversity) and similarities (universality) across cultures in order to assist people to attain and maintain meaningful and therapeutic health care practices that are culturally based. The Sunrise model or enabler (Leininger 1995, 2001) (Leininger and McFarland, 2002, 2006) served as a guide in the application of the theory. The major areas of assessment in focus in this paper were the cultural and social structure factors that the theorists assumes that clients culture values, believes and life-ways and practices that influence health and care are embedded in. These factors included; Educational, Economical, Kinship & Family, Religious & Philosophical, Culture Values Beliefs & Life-ways, Political & legal and Technological factors.

Culture, health and illness as viewed by Helman (2000) too has been looked into as it seemed relevant in further understanding the concept of culture in association to health.

A qualitative method was applied to gather data. Convenience purposive snowball sampling as described by Polti & Beck (2004) was used to recruit and collect data from seven English speaking elderly Sri Lankan immigrants. One woman and six men were interviewed. The informants were between the ages of 50 -75 living in the country over a period of at least ten years.

Data collection is based on a semi structured interview guided by Leininger's (2001) cultural and social structure dimensions where the participants' verbal descriptions of their subjective experiences of meanings and practices of staying healthy were collected.

Verbatim transcripts were typed out. Data was coded by hand and analysed to identify themes and categories. To make sense of the data collected a template analysis style (Polit and Beck 2004) was applied to which the narrative and transcribed data was systemised for description and analysis.

The findings from the study revealed the following major meanings and practices that could maintain or enhance the health and well being of elderly Sri Lankan immigrants.

Similar to the Norwegian culture the aims to do well educationally and financially were of vital importance to the Sri Lankan elderly to stay or remain healthy. Children and grand children were expected to achieve educational and financial success too as it brought them joy and happiness. But unlike the Norwegian elders, having successful well educated and financially stable siblings were also meant to guaranty a secure old age and healthy life style. Economic support and housing dependence was exhibited and practiced from children to stay or remain healthy. Economic support was extended to those in need in Sri Lanka, which was meant to be both a duty and activity that gave them mental happiness.

A dominant universal difference was health and wellbeing associated to kinship and family structure. Unlike the Norwegian elderly who live a highly individualistic and independent life, the Sri Lankan elderly exhibit close interdependence within the family and friends for care in order to maintain their health and well being. Those who have extended families live either together or in close proximity to each other readily available to extend care when needed. Those who had no immediate family, a limited family net work, or who exhibited fright in not been taken care by their children at an old age preferred to return to Sri Lanka as they got older to live with relatives in order to maintain their health or wellbeing at an old age.

The only woman informant played a central role in seeing to the health and well being of the rest of the family. In turn she too depended on the family for socio-economic support. Being taken care of the family and taking care of the family meant staying healthy to her.

Diverse religious and philosophical beliefs that influence their health beliefs and practices were exhibited unlike the Norwegians or other major immigrant groups from one particular

country. Muslims and Christians were represented too, but the dominant Hindu cultural values beliefs and practices were reflected among the majority of informants in order to maintain their health and well being.

Either a God, or a Supernatural power was meant to influence the health of some, and at times of illness and distress, connection was made to the use of prayer and the trust in God or Supernatural powers for recovery and help in addition to seeking help from the folk sector and medical profession. Diet and religion were closely associated and played a central role in their meanings and practices in staying healthy.

For others staying healthy was meant to be of how we lived and behaved. This belief could be interpreted as being influenced by both their religious teachings as well as their adaptation to a Western lifestyle.

The belief of being understood and receiving the proper treatment was also meant to be important in maintaining good health.

Even though western medicine is highly trusted, respected and used, the use of self treatment or treatment given by a relative with traditional remedies was yet practiced by some informants to treat them selves and their families. Ayurvedic treatment was meant to be trusted when western medicines failed.

All seven informants had one thing in common; they had all left the country due to political unrest and the ethnic conflict. Though their physical health may be intact, their reflections describe mental agony that could easily have a great influence on their mental health and well being. Following developments back home and longing for the former way of being was a familiar theme as a mean of staying healthy.

Discriminatory feelings associated to ethnicity and age was expressed with regards to job opportunities. Physical wastage due to alternative types of many low income jobs being taken to compensate for better paid jobs too were mentioned. These factors were also meant to have an impact on their health and well being.

Similar to the knowledge and use of modern communication technology among the present aging population of most developed countries, some of the Sri Lankan elders too have started to use and depend on the Internet and mobile phones to maintain their health and well being. Internet and mobile phones were meant and used to keep them occupied, gain

knowledge, gather and exchange information, and communicate with their friends and relatives at any time avoiding isolation and giving them a sense of security.

7.2 Recommendations

Further research on elderly Sri Lankan immigrants is necessary and desirable as there is an enormous lack of nursing knowledge in Norway and internationally.

With the increasing number of immigrants and elderly immigrants in particular, the demand for culture congruent care would increase. To serve these clients nurses need to optimize the quality of care they provide by developing relevant cultural competence. Therefore trans-cultural nursing studies and concepts should be incorporated into the curricular for student nurses in Norway too. According to Giger and Davidhizar (2004) Trans-cultural nursing concepts have already been incorporated into the curricula for student nurses in the United States and Canada. The introduction of trans-cultural nursing studies at graduate levels in Norway may also kindle the interest to pursue nursing studies and research at higher levels which seems to be lacking in this particular field.

Nurses educated in Trans-cultural nursing and minority ethnic representations on service liaison committees and health authority boards are crucial too, to ensure that the views of the minority or immigrants communities are represented and their needs taken into account when planning and providing services for the elderly of minority cultures.

When interacting with Sri Lankan elderly immigrants and their families, be sensitive to their educational and occupational levels as it is of vital importance to them to stay healthy. As the study shows Sri Lankan elderly immigrants and their families are relatively well educated and some of them have been very successful even before arriving in Norway. Many may speak both Norwegian and English in addition to their mother tongues and may resent being viewed as a disadvantage in any way.

As maintaining family and friends support is of vital importance to an Elderly Sri Lankan and their families to maintain or improve their health and well being, be sensitive to the client's kinship and family structure. The family and friends are a major source of emotional and practical support that is difficult to substitute in addition to economy and shelter being provided. But one should also keep in mind that some might not have any family networks in Norway to give them care and support needed.

Pay special attention to the Sri Lankan elderly immigrants' religious and philosophical beliefs and social cultural backgrounds as the Sri Lankan elderly may represent different religious, ethnic and may be linguistic groups unlike most other immigrants or locals. This study's informants had major different religious and ethnic backgrounds that had a significant influence on their meanings and practices in staying healthy.

Get to know about the client's alternative forms of care meant or practiced to maintain or improve their health and well being. Western medicine is highly trusted, respected and used by elderly Sri Lankans, but the use of self treatment or treatment given by a relative with traditional remedies were yet practiced by some informants to treat them selves and their families. Ayurvedic treatment was also used when western medicines were thought to have failed.

Unlike the peaceful atmosphere and well functioning law and order that surrounds the people of all ages in Norway, the informants in this study have experienced the opposite in some stage of their lives, and that is the main reason as to why they are here. They are here due to the conflict and political atmosphere that prevails in Sri Lanka, therefore special attention must be given to these factors as their meanings and experiences of staying mentally healthy have a close association to the conflict and governs their present and future plans. Feelings of discrimination experienced in Norway should also be looked into.

As the internet and use of mobile phones were essential to maintain elderly Sri Lankans' health and satisfying life-ways it is important that the authorities and the nurse preserve and encourage these health maintaining practices either in their homes or long term care institutions. The stress of transition into Norwegian culture, disruption of the normal social patterns and the availability of extended family support for elderly Sri Lankans is clearly visible in their conversations. Internet and mobile phones may compensate this disruption somewhat by giving the opportunity to communicate at any time in their own language and avoid isolation and feel close to home, their families and friends especially at a low cost. Thus supporting universal usability and accessibility of modern communication technology should be considered when addressing care to elderly Sri Lankans immigrants in order to maintain their health and well being.

7.3 Conclusion

The study shows that while a few similarities exist, there are more significant differences exhibited by Sri Lankan elderly immigrants compared to the Norwegian elderly in their meanings and practices of staying healthy. Their meanings and practices are greatly influenced by their cultural values, beliefs and experiences embedded in Educational, Economical, Kinship & Family, Religious & Philosophical, Culture Values Beliefs & Life-ways, Political & legal and Technological factors mainly inherited from their home country. Nurses and other health care professionals who do not recognise these significant similarities or differences might not possibly be able to offer culture congruent care that maintains or improves the Health and well being of these elderly clients. Thus as more Sri Lankan immigrants age in Norway, nurses and other health care professionals need to improve the quality of culture care they provide by improving their relevant cultural competence about these clients. The knowledge of the cultural values, beliefs practices and experiences in staying healthy of elderly Sri Lankan immigrants is of vital importance in order to provide culture congruent care for them to improve or maintain their health and well being in Norway.

REFERENCES

- Abeykoon, P. (2002). *Case study; Sri Lanka*. Geneva: WHO.
- Andrews, G.R., & Hennink, M.M. (1992). The circumstances and contributions of older persons in three Asian countries: Preliminary results of a cross-national study. *Asia-Pacific Population Journal*, 7(3), 127-146.
- Aftenposten, (28 April 2006). Norway's immigrants well educated. Retrieved June 6, 2008 from <http://www.aftenposten.no/english/local/article1297637.ece>
- Aggleton, P. (2003). *Health*. London: Routledge.
- Ahmed, S.M., & Lemkau, J.P. (2000). Cultural Issues in the Primary Care of South Asians. *Journal of Immigrant Health*, 2(2), 89-96.
- Ahlberg, N., Aambø, A., & Gihle, I (red.). (2005). *Utfordringer innen helse og omsorg blant minoriteter: Tilbakeblikk og erfaringer*. NAKMIs skriftserie om minoritetes helse. nr.1/2005
- Atkinson, D. (1998). *Care Matters. Concepts, Practice and Research in Health and Social Care*. London: Sage Publications Ltd.
- Baluyot, C.M.A. (1999). *Primary nursing health care services and ethnic minority elderly patients*. Hovedfagsoppgave i Sykepleievitenskap: Universitetet i Oslo.
- Basuray, J. (1997). Nurse Miss Sahib: colonial culture bound education in India and transcultural nursing. *Journal of Transcultural Nursing*, 9(1), 14-19.
- British Broadcasting Corporation. (2006). Retrieved October 24, 2006, from http://news.bbc.co.uk/go/pr/fr/-/2/hi/south_asia/6065646.stm.
- Birkeland, R. (1990). *Om å bli gammel i et annet land*. Prosjektrapport: Oslo kommune.
- Blom, S., & Ramm, J. (1998). Ikke flere syke, men når de først blir syke...*Samfunnsspeilet*, 3. Oslo: Statistisk sentralbyrå.
- Browne, H. (2000). *Accessibility and Usability of Information Technology by the Elderly*. Retrieved July 4, 2008, from <http://www.otal.umd.edu/uuguide/hbrowne/>
- Cantor-Graae, E., Pedersen, C., Mc Neil, T., & Mortensen, P. (2003). Migration as a risk factor for schizophrenia: a Danish population –based cohort study. *British Journal of Psychiatry*, 182, 117-122.

Carling, J. (2004). *Policy options for increasing the benefits of remittances*, Working paper No.8, Centre on Migration, Policy and Society (COMPAS), University of Oxford.

Carling, J. (2005). *Migrant Remittances and development cooperation*, PRIO Report 1/2005, Oslo: PRIO.

Chang, T.P. (1992). Implications of Changing Family Structures on old-Age Support in the ESCAP region. *Asia-Pacific Population Journal*, 7(2), 49-66.

Corbin, J., & Strauss, A. (1998). *Basics of Qualitative Research*. Thousand Oaks, California: Sage Publications.

Dawes, T., & Thoner, G. (1997). *Frykter en alderdom i Norge*. Retrieved March 15, 2001, from <http://www.sykepleien.no/artikler/1997/17/a01/artikel.htm>

De Vries, J. (2001). Mental health issues in Tamil refugees and displaced persons Counseling implications. *Patient Education and Counseling*, 42(1), 15-24.

Department of Ayurveda. (2006). Retrieved December 7, 2006, from <http://ayurveda.gov.lk/>.

Erdal, M.J. (2006). *Contributing to development? Transnational activities among members of the Tamil Diaspora in Norway*. Masteroppgave i Samfunnsgeografi: Universitetet i Oslo.

Eshleman, J. (1992, November). Death with dignity: significance of religious beliefs and practices in Hinduism, Buddhism, and Islam. *Today's OR Nurse*, 19-20.

Fuglerud, Ø. (1997). Migrasjon: Felleskap og endring, in Hollerup O. and Stokke, K., *Sri Lanka: Nasjonalisme, identitet og migrasjon*, Oslo: Tano Aschehoug.

George, J.B. (1995). *Nursing Theories. The Base for Professional Nursing Practice*. USA: Prentice-Hall International, Inc.

Giger, J.N., & Davidhizar, R.E. (2004). *Transcultural Nursing, Assessment & Intervention*. USA: Mosby, an affiliate of Elsevier.

Graneheim, U., & Lundman, B. (2003/2004). "Qualitative Content Analysis in Nursing Research: Concepts, Procedures and Measures to Achieve Trustworthiness". *Nurse Education Today. Elsevier Science Ltd*, 1-28.

Hanssen, I. (1998). *Helsearbeid i et flerkulturelt samfunn*. Oslo: Universitetsforlaget AS.

- Hayward, A.L., & Sparkes, J.J. (1988). *The Concise English Dictionary*. Poole, Dorset: New Orchard Editions Ltd.
- Helman, C.G. (2000). *Culture, Health and Illness 4th Ed*. London: Butterworth Heinemann.
- Helman, C.G. (2007). *Culture, Health and Illness 5th Ed*. London: Hodder Arnold.
- Higgins, P.G., & Learn, C.D. (1999). Health practices of adult Hispanic women. *Journal Of Advanced Nursing*, 29(5), 1105-1112.
- Hussainmiya, B.A. (2001). Malays in Sri Lanka. *Borneo Bulletin*, (8), 1-13.
- Jan, R., & Smith, C. (1998). Staying Healthy in Immigrant Pakistani Families Living in the United States. *Journal of Nursing Scholarship*, 30(2), 157-159.
- Klienman, A. (1980). *Patients and Healers in the Context of Culture*. Berkley: University of California press.
- Klienman, A. (1984). *Patients and Healers in the Context of Culture*. Berkley: University of California press.
- Kvale, S. (1996). *InterViews, An Introduction to Qualitative Research Interviewing*. Thousand Oaks, California: Sage Publications.
- Lie, B. (2004). *Fakta om ti innvandrergupper I Norge*. Oslo: Statistisk Sentralbyrå.
- Leininger, M. (1995). *Transcultural Nursing: Concepts, Theories, Research & Practices*. New York: McGraw-Hill, Inc.
- Leininger, M. (2001). *Cultural Care Diversity and Universality: A Theory of Nursing*. Sudbury, Mass: Jones and Bartlett.
- Leininger, M., & McFarland, M. (2002). *Transcultural nursing: Concepts, theories, research and practices*. New York: McGraw-Hill, Inc.
- Leininger, M. & McFarland, M. (2006). *Culture Care Diversity and Universality: A Worldwide Nursing Theory*. Sudbury, Mass: Jones and Bartlett.
- Littlewood, R., & Lipsedge, M. (1997). *Aliens and alienist. Ethnic minorities and psychiatry*. London: Unwin Hyman.
- Laake, K. (2003). *Geriatry I praksis. 4 utg*. Gjøvik: Gyldendal Norsk Forlag AS.

- Malone, M.J. (1975). Society-SINHALESE, Culture summary. Retrieved January 27, 2005, from <http://web5.silverplatter.com/webspirs/showFullRecordContent.ws>
- Martin, L.G. (1990). The status of South Asia's growing elderly population. *Journal of Cross-Cultural Gerontology*, 5(2), 93-117.
- Mickus, M.A., & Luz, C.C. (2002). Televisits: sustaining long distance family relationships among institutionalized elders through technology. *Aging and Mental Health*, 6(4), 387-396.
- Moen, B. (1993). *Eldre innvandrere i Gamle Oslo*. NGI- Rapport Nr. 4. Oslo: NGI.
- Moen, B. (2002). *Når Hjemme er et annet sted. Omsorg for eldre med minoritetsetnisk bakgrunn*. Nova - rapport 8/02. Oslo: Norsk institutt for forskning om oppvekst, velferd og aldring.
- Morse, J.M., & Field. P.A. (1995). *Qualitative research methods for health professionals*. Thousand Oaks, California: Sage Publications.
- Morse, J. M., & Richards, L. (2002). *Read me first: For a users guide to qualitative methods*. Thousand Oaks, California: Sage Publications.
- Orjuela, C., & Sriskandarajah, D. (2006). *The Sri Lankan Tamil Diaspora – Warmongers or Peacebuilders?* Nordic conference on War and peace in Sri Lanka, Uppsala University, 26-27 January 2006
- Orions Store Verdens Atlas. (1999). Oslo: Orion Forlag AS.
- Papadopoulos, I. (1999). Health and illness beliefs of Greek Cypriots living in London. *Journal of Advanced Nursing*, 29(5), 1097-1104.
- Petitjean, P., Jami, C., & Moulin, A. M. (1992). *Science and Empires*. Dordrecht: Kluwer Academic Publishers.
- Pernice, R., & Brook, J. (1996). Refugees' and immigrants' Mental Health: Association of Demographic and post-immigration Factors. *Journal of Social Psychiatry*, 136(4), 511-519.
- Perera, P.D.A. (1999). Population trends in Sri Lanka: Implications for the family and elderly. The family and older persons in Bangladesh, Pakistan and Sri Lanka. *ESCAP, UN-Asian population studies*, 151, 115-158.

Polit, D. F., & Beck, C.T. (2004). *Nursing Research: Principles and Methods*. 7th ed. Philadelphia: Lippincott Williams & Wilkins.

Rahman, F. (1989). *Health and Medicine in Islamic tradition*. New York: Crossroads.

Silveira, E., Skoog, I., Sundh, V., Allebeck, P., Steen, B. (2002). Health and well-being among 70 year old migrants living in Sweden – results from the H 70 gerontological and geriatric population studies in Gøteborg. *Soc. Psychiatry Psychiatr Epidemiol*, 37, 13-22.

Silveira, E., Ebrahim, S. (1998) Social determinants of Psychiatric morbidity and well-being among immigrant elders and whites in East London. *International journal of Geriatric Psychiatry*, 13, 801-812.

Spittel, R.L. (2001). *Far off things* (ed.3). Colombo: Sooriya Publishers.

SSB. (2004). Official statistics of Norway Statistic year book, 2004. Statistisk sentralbyrå

Statistisk sentralbyrå, (2007). www.ssb.no/innvregsys-en/

Stortingsmelding nr: 50 (1996-97): *Handlingsplan for eldreomsorgen. Trygghet – respekt-kvalitet*. Oslo: Social- og helsedepartementet.

Strauss, A. L., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (ed.2). Thousand Oaks CA: Sage

Sundquist, J., Bayard-Burfield, L., Johansson, L., & Johansson, S. (2000). Impact of Ethnicity, Violence and Acculturation on Displaced migrants: Psychological Distress and Psychosomatic Complaints among Refugees in Sweden. *Journal of Nerv' Mental Disorders*, 188(6), 357-365.

Slagsvold, B. (1999). *Blir omsorgen borte? Eldre omsorgens hverdag i den senmoderne velferdsstaten*. Ad Notam: Glydendal AS.

Siddhisena, K.A.P. (2005). *Soci-Economic Implications of ageing in Sri Lanka: an overview*. Oxford: Oxford Institute of ageing.

Srinivasan, P. (1995). National health policy for traditional medicine in India. *World Health Forum*, 16, 190-195.

Thapa, S.B., Hauff, E. (2005). Gender differences in factors associated with psychological distress among immigrants from low-and middle-income countries. Findings from the Oslo Health Study. *Soc Psychiatr Epidemiol*. 40(1), 78-84

The New Shorter Oxford English dictionary. (1993). Oxford: Oxford university press Inc.

THE WORLD GUIDE. (2001/2002). *An alternative reference to the countries of our planet*. Oxford, United Kingdom: New International Publications Ltd.

Thoner, G. (1997). Tiltak for elder innvandrere. NOVA rapport 26/97. Oslo: NOVA.

UDI. (1991/92). *Tamilene på Sri Lanka*. Skien: Senter Grafisk.

Van Hear, N., Pieke, F., & Vertovec, S. (2004). *The contribution of UK based Diasporas to development and poverty reduction*, a report by the ESRC Centre on Migration, Policy and Society (COMPAS), University of Oxford for the department of international development

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany, N.Y.: State University of New York Press.

Vassenden, K. (1997). *Innvandrere I Norge. Hvem er de, hva gjøre de og hvordan leve de?* Oslo/Kongsvinger: Statistisk sentralbyrå.

Virtual Library - Sri Lanka (2005). Sri Lankan People, Ethnic Groups and Cast. Retrieved August 13, 2005 from <http://www.lankalibrary.com/>

Weerasuriya, N., & Jayasinghe, S. (2005). A preliminary study of the hospital-admitted older patients in a Sri Lankan tertiary care hospital. *Ceylon Medical Journal*, 50, 18-19.

WHO (2001). *Men Ageing And Health: Achieving health across the life span*. Geneva: WHO.

Wiking, E., Johansson, S., & Sundquist, J. (2004). Ethnicity, acculturation and self reported health. A population based study among immigrants from Poland, Turkey and Iran in Sweden. *Journal of Epidemiol Community Health*, 58(7), 574-82.

APPENDIXES

Appendix 1: Ethical clearance 1



UNIVERSITETET I OSLO

DET MEDISINSKE FAKULTET

Professor Bodil Ellefsen
Institutt for sykepleievitenskap og helsefag
Universitetet i Oslo

Regional komité for medisinsk forskningsetikk
Sør-Norge (REK Sør)
Postboks 1130 Blindern
NO-0318 Oslo

Telefon: 228 44 666

Telefaks: 228 44 661

E-post: rek-2@medisin.uio.no

Nettadresse: www.etikkom.no

Dato: 07.11.05

Deres ref.:

Vår ref.: S-05311

S-05311 Gammel blant fremmede. Hva opplever eldre srilankiske innvandrere bosatt i Norge, som god helse?

Komiteen behandlet søknaden i sitt møte onsdag 26.10.05.

Komiteen har følgende merknad til prosjektsøknaden:

1. Intervjuobjektene er tenkt rekruttert fra slektninger og venner av kjente kontakter. Komiteen ber om nærmere refleksjoner om hvordan en slik "nærrekruttering" kan påvirke både frivilligheten til å delta og hva som kommer fram av informasjon under intervjuene, samt forslag til alternative rekrutteringsmåter.

Komiteen har følgende merknader til informasjonsskrivet:

1. Informasjonsskrivet bør ha heading med logo(er), evt. bør det på annen måte fremgå tidlig hvor informasjonsskrivet kommer fra.
2. "Forespørsel om deltagelse i forskningsprosjekt (og evt. prosjektets tittel)" bør være hovedoverskriften på informasjonsskrivet. Hensikten med prosjektet og hvorfor pasienten kontaktes bør komme først, ikke personlige opplysninger om forskeren.
3. Utformingen av forespørselen og informasjonsskriv bør være nøytral i sin form. Slik den nå foreligger, inneholder den overtalende formuleringer (som "I would greatly appreciate –"), som bør fjernes.
4. Det må angis dato for når opptakene fra intervjuene seinest vil bli slettet.
5. Under omtalen av at det er frivillig å delta og at man kan trekke seg, må det presiseres at avslag på forespørsel eller det å trekke seg, ikke vil ha noen konsekvenser for direkte eller indirekte relasjoner til intervjueren.
6. Samtykkeerklæringen skal kun inneholde samtykket. Deltakerne skal ved sin underskrift ikke behøve å stadfeste annet enn å ha mottatt informasjon om prosjektet og at de ønsker å delta. Deltakerne skal ha kopi av både informasjonsskriv og samtykkeerklæring.

Vedtak:

"Komiteen ber om svar på merknader samt revidert informasjonsskriv og samtykkeerklæring. Forutsatt tilfredsstillende tilbakemelding, vil prosjektet tilrås. Komiteens leder og sekretær tar stilling til dette ved mottatt svar."

UNIVERSITETET I OSLO
Det medisinske fakultet

Side 2 av 2

Med vennlig hilsen



Hans Erik Rugstad
Professor dr.med.
Leder



Tone Haug
Rådgiver
Sekretær

Kopi: Masterstudent: H.R. Ajith Senake Goonetilleke, Institutt for sykepleievitenskap og helsefag,
Universitetet i Oslo

Appendix 2: Response to Ethical clearance 1

**Regional Komité for medisinsk forskningsetikk Sør- Norge (REK Sør)
Ved Professor dr.med. Erik Rugstad / Tone Haug rådgiver/sekretær
Postboks 1130 Blindern
NO-0318 Oslo**

28.11.05

Deres ref: S-05311

S-05311 Gammel blant fremmede. Hva opplever eldre srilankiske innvandrere bosatt i Norge, som god helse?

Growing old amongst strangers. To determine the meaning of staying healthy as experienced by elderly Sri Lankan immigrants living in Norway.

With reference to your letter dated 07.11.05, received by me on 20.11.05 with regards to the above project

Attached is;

- 1. A reflection over comment 1 and an explanation of the recruiting process.**
- 2. An adjusted information letter with the recommendations made by the committee.**
- 3. An adjusted letter of consent with the recommendations made by the committee.**

Awaiting a reply to the decision taken regarding the above,

**Thank You
Yours sincerely**

**H.R. Ajith Goonetilleke
Masterstudent
Institutt for Sykepleievitenskap og Helsefag
Universitetet i Oslo
Pb 1153 Blindern**

**Post add.
Havnabakken 12
0874 Oslo
Tlf: 22182987 /47040242
E mail h.s.goonetilleke@studmed.uio.no**

Kopi: Professor Bodil Ellefsen

S-05311 Gammel blant fremmede. Hva opplever eldre srilankiske innvandrere bosatt i Norge, som god helse?

Growing old amongst strangers. To determine the meaning of staying healthy as experienced by elderly Sri Lankan immigrants living in Norway.

1. A reflection over comment 1 and an explanation of the recruiting process.

First or foremost I would like to define or explain what I mean when I say that the interview objects would be recruited through relatives and friends of known contacts, and the reason behind choosing this method.

Although being a Sri Lankan in origin myself, I represent a total different community to the majority of Sri Lankans living in Norway. Therefore my access to the majority of probable subjects is limited to a few contacts from the majority community whom I have got to know during my education in Norway and places of work. It is they whom I mention as known contacts. I expect these contacts to put me in touch with their elderly in society (whom I refer to as family and friends) whom in turn can recommend other recruits as the study proceeds (**Non probability Convenience snowball sampling and purposive sampling**). I have no personal relationship to the intended subjects.

According to Polit and Beck (2004 p 292), Non probability convenience sampling “entails using the most conveniently available people as study participants” Snowball sampling also called network sampling or chain sampling is a variant of convenience sampling. With this approach, early sample members are asked to identify and refer other people who meet the eligible criteria. This method of sampling according to Polit and Beck (2004) is often used when the research population is people with specific traits who might otherwise be difficult to identify. Polit and Beck (2004) state that snowballing begins with a few eligible study participants and then continues on the basis of referrals from those participants until the desired sample size has been obtained.

Sri Lankans are a multicultural society in Sri Lanka, where the main ethnic groups are the, Sinhalese, Tamils, Muslims, and Burgers (descendants of the colonial Europeans mainly the Portuguese, Dutch and the British). With my ethnic background it could be easily said that even though not visible to a stranger, the ethnic communities living in Norway tend to keep to themselves. It is a very few who build bridges amongst also a politically divided community from before. Many cultural factors too catalyze this divide, namely religion, language and geographical origins. These factors too make recruitment advisable through known contacts.

My study includes not patients but elderly healthy Sri Lankans who are not institutionalized but living at home. Therefore this too makes it difficult in recruiting the subjects.

No participants would be forced to participate. Participation will be on a purely voluntary basis.

Appendix 3: Inquiry to participate



UNIVERSITETET I OSLO

DET MEDISINSKE FAKULTET

Institutt for sykepleievitenskap og helsefag

Seksjon for sykepleievitenskap

Postboks 1153 Blindern

N-0318 OSLO

Besøksadresse: Nedre Ullevål 9

Telefon: +47 22 85 05 60

INQUIRY TO PARTICIPATE IN A RESEARCH PROJECT, “GROWING OLD AMONGST STRANGERS”

The project will investigate the meaning of staying healthy as experienced by elderly Sri Lankan immigrants living in Norway.

The purpose of this research project will be to generate knowledge about culturally related factors that are most meaningful to elderly Sri Lankan immigrants in staying healthy after living in Norway for some time.

The ultimate goal being that this knowledge gained will help especially the nursing sector and the rest of the Norwegian health sector too, to understand, plan for the future and provide a service that is more culturally orientated and suited to meet the needs of elderly Sri Lankans.

This investigation forms a part of my Master of Science thesis at the Institute for Nursing Science, Faculty of Medicine University of Oslo.

As a means of getting the information required I want to interview eight Sri Lankan immigrants of both sexes between the age group of 50 to 75 years, living in the country for over a period of ten years.

Participation would be on a purely voluntary basis.

In case you volunteer;

You can at any time withdraw from the study and no explanation for your withdrawal will be required. This will not have any direct or indirect consequences to any forms of relationships with the interviewer.

The intended time duration per interview is approximately 1.5 hours.

To facilitate the process of interviewing the conversations will be tape recorded.

All data recorded will be made confidential, anonymous and treated according to the required ethical and electronic regulations.

The tapes will be erased at the end of the study, latest end August 2006.

Attached is a letter of consent which must be returned to me in case you will take part.

I will call in advance and determine a date, time and place suitable to you for the interview.

Please contact me on. 22182987 / 47040242

E-mail h.s.goonetilleke@studmed.uio.no or my advisor Professor Bodil Ellefsen
tlf +4790895827 E-mail, bodil.ellefsen@medisin.uio.no if you need further clarification.

Thank You
Yours sincerely

H.R Ajith Senake Goonetilleke RN, MSC student
Oslo 28.11.05

Appendix 4: Letter of consent 1

CONSENT TO PARTICIPATE IN THE RESEARCH PROJECT “GROWING OLD AMONGST STRANGERS”

I have received information on the research project “Growing old amongst strangers” to investigate the meaning of staying healthy as experienced by elderly Sri Lankan immigrants living in Norway.

I have read and understood the information sent to me, and hereby consent to being interviewed.

Date:

Participant:

Telephone No:

H.R. Ajith Senake Goonetilleke
Havnabakken 12 0874 Oslo

Tlf. 22182987 / 47040242

Appendix 5: Ethical clearance 2



UNIVERSITETET I OSLO

DET MEDISINSKE FAKULTET

Professor Bodil Ellefsen
Institutt for sykepleievitenskap og helsefag
Universitetet i Oslo
Postboks 1130 Blindern

Regional komité for medisinsk forskningsetikk
Sør- Norge (REK Sør)
Postboks 1130 Blindern
NO-0318 Oslo

Telefon: 228 44 666

Telefaks: 228 44 661

E-post: rek-2@medisin.uio.no

Nettadresse: www.etikkom.no

Dato: 20.01.06
Deres ref.:
Vår ref.: S-05311

S-05311 **Gammel blant fremmede. Hva opplever eldre srilankiske innvandrere bosatt i Norge, som god helse?**

Vi viser til brev datert 28.11.05 med vedlegg: revidert informasjonsskriv.

Komiteen tar svar på merknader til etterretning.

Komiteen har følgende merknad til revidert informasjonsskriv og samtykkeerklæring:

1. "...and understood" bør strykes, da det er vanskelig å vite om så er tilfelle.


Komiteen tilrår at prosjektet gjennomføres.

Vi ønsker lykke til med prosjektet!

På grunn av stor saksmengde har vi dessverre ikke kunnet svare så raskt som vi ønsker.

Med vennlig hilsen

Kristian Hagestad (sign)
Fylkeslege cand.med., spes. i samf.med
Fungerende leder


Tone Haug
Rådgiver
Sekretær

Kopi: Masterstudent H.R. Ajith Senake Goonetilleke, Institutt for sykepleievitenskap og helsefag,
Universitetet i Oslo, Postboks 1130 Blindern

Appendix 6: Letter of consent 2

**CONSENT TO PARTICIPATE IN THE RESEARCH PROJECT
“GROWING OLD AMONGST STRANGERS”**

I have received information on the research project “Growing old amongst strangers” to investigate the meaning of staying healthy as experienced by elderly Sri Lankan immigrants living in Norway.

I have read the information sent to me, and hereby consent to being interviewed.

Date:

Participant:

Telephone No:

H.R. Ajith Senake Goonetilleke
Havnabakken 12 0874 Oslo

Tlf. 22182987 / 47040242

Appendix 7: Interview guide

To investigate the meaning of “staying healthy” as experienced by elderly Sri Lankan immigrants living in Norway.

Participant No:

Age:

Gender:

Marital status:

Employment:

Level of education:

Length of Stay in Norway:

The initial question

1. Can you tell me about a time, that you believe is a good example of what the experience of staying healthy is like for you here in Norway?

Supplementary questions to the initial question:

2. Economic factors;

Is there any particular incident or incidents that you could associate with regards to money or work playing a part in you keeping healthy here in Norway?

3. Educational factors;

Is there any particular incident or incidents with regards to your health that you could associate that your educational background had a part to play?

4. Kinship and social factors;

Your family and friends, how would you relate them to you keeping healthy, is there any incident or incidents that stands out in their participation?

5. Cultural values, beliefs and life ways;

Are there any particular cultural values, beliefs or actions that you can associate that plays an important part in you staying healthy? (Your Health beliefs and practices, western medicine, natural medicine)

6. Religious and philosophical factors;

Are there any particular Religious and philosophical factors (your religious beliefs and practices) that you believe influence you or stands out, in you keeping healthy?

7. Political and legal factors;

Are there any particular political or legal factors that influence your meaning and practices of keeping healthy, special events or happenings?

8. Technological factors; (the things you do to achieve your goals of staying healthy using modern technologies)

Is there anything particular and special, that you associate that you do, that helps you to keep healthy? Tell me something about it and your experience.