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Illuminating the Health and Habitus of a Finnish Community in New Zealand through Narratives across Generations

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*A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy, The
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Abstract

This research is about the health understandings and practices of a group of people in New Zealand who had a shared Finnish migrant history. The aim was to discover how policy and this shared history shaped the health experiences of three generations of this group who were categorised as European, but were not Anglo-Celtic. The main research procedures were participant observation and in-depth interviews with 25 participants, using ethnographic and narrative methodologies within the theoretical frame of habitus (Bourdieu, 1999).

My enquiry into lay models of health revealed a process of narrative sense-making, which led to understandings that differed from the ‘medical gaze’ of diverse Western biomedical models. These lay models influenced whether or not health care was sought and in what circumstances, the kind of care that was sought, and the approach to compliance with medical advice. Understandings and practices were found to be generated, and reproduced, across generations through the sedimentation of seemingly mundane everyday experiences. The research also found that ways of thinking and acting about health were influenced by life experiences, including the experiences of migration and policy, and by access to the power and resources those experiences provided (or didn’t provide). The study concluded that even if people are categorised as ‘white’ and appear physically ‘British-like’, their unique habitus may influence the way they think, act and feel about health in ways not predicted by policy or ethnic categorisation. This has implications for health policymaking and the provision of health care, particularly in the generational migrant context.

Dedication



This research is dedicated to my maternal grandparents – Paavo Rikhard Sandberg and Toini Maria Sandberg (nee Viitakangas) – who courageously left everything and everyone they had ever known to embark on an adventure with their two girls to the other side of the world. They have seeded this adventurous spirit in their daughters, grandchildren and great grandchildren. Like the leafy, fragrant boughs of the koivuⁱ that willingly anchor themselves to the trunk, we feel the strand that connects and gently tugs us back to our Finnish roots.

My sincere thanks to all the research participants who, without exception, gave of themselves generously and unreservedly. It has been a true privilege to document

your thoughts and experiences. In addition, I am grateful to the following people for their advice and support in defining the research purposes and scope, and for providing translation and/or advisory and review services throughout the study: Paavo Sandberg (my maternal Pappaⁱⁱ, first generation Finnish migrant) who along with my Mummuⁱⁱⁱ read countless drafts and gave me unconditional support and encouragement; Hannele van der Molen (nee Sandberg, my mother, 1.5 generation Finnish migrant) who painstakingly proof read screeds of text and who believed in me; and Jason Viitakangas (my cousin, 2nd generation descendant of Finnish migrant) who supported me in his quiet way. Thanks also to Rod Perkins, whose advice and encouragement particularly in the initial stages of the thesis, set me on this sometimes painful but often thrilling path. Rod also pointed me in the direction of the two lovely ladies who have been by my side on this journey, giving wise counsel and challenge in equal measure – thank you Nicola North and Julie Park, you have enriched my life.

i Silver Birch – Finland's national tree

ii Grandfather

iii Grandmother

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Chapter 1. The Fields of Migration and Community Health

This study set out to answer the question: What are the health understandings and practices of a Finnish migrant group and their descendants in New Zealand, what has influenced these understandings and practices, and how have these developed and changed over three generations? In this introductory chapter the study is situated within the fields of migration and community health, my motivation for investigating the study questions is revealed, and information is provided to orientate the reader to the thesis which unfolds as a story with each chapter building on the last. While migration is not the primary concern of the research, it does provide a lens with which to view multigenerational health understandings and practices. Migration is explored inasmuch as it is proposed to be one of many life experiences that influence how people think, feel and act with regards to health, but this is not a study of migration theory or the impact of migration on health indicators (see Lassetter and Callister's (2009) review of literature on the impact of migrant on the health of voluntary migrants in Western societies, for example).

Many people have had some experience of the phenomenon Castles and Miller (2003, p. 1) termed the "age of migration". The United Nations (2006) reported that in 2005, three per cent of the world population (or 191 million persons) lived outside their country of birth, and that international migration was a growing phenomenon (United Nations, 2008). By 2010 the estimated number had grown and Urquia and Gagnon (2011) stated the number of international migrants was estimated to be 213 million. New Zealand is no exception to this growing phenomenon with the Department of Labour (2006) reporting that one in five New Zealanders were born overseas, and predictions are that New Zealand will have even greater ethnic diversity in the future (Statistics New Zealand, 2007).

The health experience of migrants is therefore an issue of global importance. Differing rates of use of health services by migrant groups (as opposed to non-migrants) have been reported for quite some time in a number of countries (Colucci, Minas, Szwarc, Paxton, & Guerra, 2012; Epp, 1986; Jackowska et al., 2012; Karmi, 1996; Powles & Gifford, 1990) and Grondin (2004, p. 1) advocated that: "...well-managed migrants' health presents opportunities for improving global health, for the benefit of all societies." Migrants bring with them patterns of thinking and acting, which have been shaped by their experiences and can in turn influence whether or not health services are used, or preventative health recommendations are complied with. Migrants also bring with them genetic, socioeconomic, environmental and epidemiological backgrounds that shape their health experience (Grondin, 2004).

The health experience of migrants is also a New Zealand issue. Monitoring the health of multi-cultural New Zealand, and monitoring inequalities in health between ethnic groups, is one of the enduring goals of the New Zealand Health Strategy (Minister of Health, 2000). This thesis has a particular interest in white non-British migrants in New Zealand, and explores the experiences of one of these ‘white minorities’ in order to gain a greater understanding of health in multi-cultural New Zealand.

When my Finnish Pappa (grandfather) retired from the Tasman Pulp & Paper Company⁴ in Kawerau he was overweight, unfit, a smoker and drinker. He decided to lose weight, run marathons, quit smoking cold turkey, and moderate his alcohol intake. He has achieved every goal and told me he believes it is possible for anyone to live to more than 100 years old. I have often wondered what makes him think and act this way, and if this way of thinking does in fact make it more possible to live a long healthy life. At 86 at the time of writing this thesis, he appeared to have made very few concessions to the aging process. I have also wondered if being a Finn has influenced how he thinks about health, and if the way he thinks about health has influenced how he acts. Perhaps the way he makes his way in the world has influenced me and my children.



Figure 1 Pappa on a family holiday in Finland at 82 Years of Age (June 2008)

I have observed the experiences migrants have with our health system first hand and I wonder if we are doing enough to accommodate the health needs of white non-British migrants such as the Finns, the Dutch and the Danes, somewhat silent and invisible minorities in health policy. Despite having lived

⁴ Hereafter referred to simply as Tasman or Uncle Tasman, as do the participants in the study.

productive and social lives in New Zealand for most of their adulthood, I have observed the struggles of a number of Finnish men in their 80s with our health system. One of the participants in the study, Niilo, an intelligent and professional man, struggled to have his needs met in residential care. Many times he told my Mummu who visited him regularly that the “girls” at the rest home were very nice but they just did not understand him. His English language had deteriorated, but there is more to understanding than a limited English ability. While he was able to make his basic needs known, the nuances of the typically Finnish short but meaningful comments were not understood. He passed a number of comments to me about how he wanted to visit his home where his wife still lived, and how walking was important for health. He told me that if he could walk he could visit his home because he would be able to walk from the car into the house. I wondered how many times he had made these comments to nursing staff and they had interpreted them as nothing more than passing conversation? I visited Niilo a number of times and took him to visit his wife at their home once. I also helped him to take a short walk out on to his patio at the rest home. After his walk outside he beamed a smile at me and said “now, I am strong again”. Why had the staff not helped Niilo? He could have been walking every day!

Another Finnish man I knew was taken into hospital and needed to transition into residential care. However, hospital staff could not get him to sign the appropriate paperwork and he was labelled as a difficult and ornery patient. With no close family left in the district, various phone-calls were made and a translator found from the Finnish community. It turned out that the stress of not understanding what was going on, and not having his concerns understood, had compromised his ability to speak in English which had in turn exacerbated the entire process. The staff were frustrated by this man who could not speak English properly, and seemingly would not comply with instructions. He was frustrated with staff who would not listen to him. He was placed in an out-of-town care facility but his desire was to move into residential care in Kawerau; up until the day he died he was waiting for a telephone call to say he could move back ‘home’. He did not know that the residential care facility in Kawerau would not take him because he was viewed as too difficult for staff to manage. The out-of-town care facility made his bed in the usual way by tucking in the sheets tightly. The man caught his leg on the sheet one morning, falling to the floor and breaking his neck. He died instantly. My family said he died because his bed had never been made like that before because Finns do not tuck in sheets like Kiwis, they sleep on fitted sheets with duvets on top.

Finally, another migrant Finn needed an operation but was unable to get onto the list for treatment because he consistently under-reported the severity of his symptoms to specialists. Perhaps this was because Finnish men tend to suffer in silence, and their defining characteristic of 'sisu' (grit and guts) does not translate well to an elective services scoring system. Eventually, he got on to the list but chose not to go through with the surgery at the last minute. Having researched the surgery on the internet he had come to the conclusion that his blood pressure was too high to safely have the procedure.

It is within this migrant context that I selected the field of community health for my doctoral thesis. Messias (1997, p. 9) proposed that:

In order to provide sensitive and appropriate care, professionals need more than 'cultural' knowledge. They must have an understanding of the ways in which experiences such as migration, work and health may be played out in the daily lives of immigrants, and the multiple meanings of those experiences.

Understanding the influence of migration on community health is one way to tell the story of a multigenerational group in New Zealand, and adds to the small collection of published research on the experiences of white non-British migrants in New Zealand such as the Dutch, German and Polish (B Bonisch-Brednich, 1999; B Bonisch-Brednich, 2002; Sawicka-Brockie, 1987; Tap, 2007). This thesis tells the story of a group of Finns who came to New Zealand in the 1950s to work at the Tasman Mill and live in Kawerau. It also tells the story of their children who came with them from Finland, and their grandchildren who were born in New Zealand. This narrative can broaden our understanding of this and other groups with a multigenerational migrant history. It can also inform the policy makers and providers of health services who are charged with meeting the diverse health needs of our generational multicultural society.

I am a New Zealand born daughter of a Finnish migrant and have grown up in two worlds. The ethnographic study methodology encompasses both my perspective as an outsider, and an insider, as I aim to enrich the portrait of a people through a portrait of self (Gensuk, 2003). A short autobiographic account lays transparent my insider status (Section 1.1 below). A brief introduction to Finns and Finland in Appendix One provides some context and insight to the participant group for those unfamiliar with Finns and Finland.

1.1. Migration and Me



Figure 2 Me in Sweden Circa 1973

I have lived my family life surrounded by migrants. My Pappa, Mummu, Mum and Aunty migrated to New Zealand from Finland in 1959 when my Mum was nine years old. They were part of a group of Finns who moved to Kawerau to work at the Tasman Mill in the 1950s and 1960s. My Dad was a British migrant who came to New Zealand from Manchester when he was seven. When I was four, my Mum and I went to Sweden and Finland on an overseas adventure. While we were away my Dad died. He was working on an NZBC⁵ radio mast when it collapsed and he fell 40 feet to the ground. He was only 26 years old. Mum and I decided to make our life in Sweden for a while. When I was five, my Mummu and Pappa thought I should come back to New Zealand to live with them and go to school, because at that time in Sweden you started school at aged seven. They thought my Mum should have a chance at a young person's life and stay in Sweden for a while. Six months later, my Mum came home with a handsome Frieslander⁶, who was to become my Dad.

When I was 19 I married the son of an immigrant Irishman. Mum and my Dad thought it would be a good idea for us to learn to rely on each other and so they gave us one-way plane tickets for a wedding present. We said our goodbyes to family and friends at our wedding reception and flew out the next day. We visited family in England, Ireland, Israel, the Netherlands and Finland before having our overseas adventure. We returned to make a life in Auckland two years later. Twenty years would pass before I would return to Finland.

⁵ New Zealand Broadcasting Corporation

⁶ Friesland or Fryslân is a province in the north of the Netherlands

For a number of years the Finnish government paid for my Mummu and Pappa to visit a Rehabilitation Centre because Pappa is a war veteran. Mostly they chose to travel to a Finnish Centre so they could visit family at the same time. In 2008 the girls in the family decided to have an overseas adventure and meet up with Mummu and Pappa in Finland to celebrate Pappa's 82nd birthday, along with my Aunty and her family from Israel. While Mummu and Pappa continued to astound us with their exceptionally good health, the unspoken reality of the inevitable march of time gnawed at us all and we jumped at the chance to travel back to the home country as a family. We made our various holiday journeys to Finland and converged at a house by the lake in Southern Finland for a traditional Finnish summer holiday. As others headed home, my daughter and I travelled on with Mummu and Pappa to Kemi in the north of Finland where my family's migration journey began. Before we left for our trip, Pappa asked my daughter to record how she felt when she returned to Auckland Airport after her trip away. She told him that she was very excited to see her father and brother, and that she felt so proud of New Zealand coming through the airport with the cultural displays and Maori music. According to her this was the best airport we had been to - high praise indeed considering we had just taken 13 flights over five weeks. Seeing brown faces made her happy and feel like we were finally home. A few months after the trip she shared the following recollections with me:

You know we saw some cool things in Rome and Venice and Paris but I was the most excited to go to Finland because I feel, you know, connected to my Finnish side of the family because of iso Mummu⁷ and Pappa Vaari⁸. I always wanted to go and it was special to go with them because of all the stories they told us about where they grew up and used to live before they came to New Zealand. I thought the language was a barrier though and it would have been better if I knew how to speak Finnish. It sort of felt quite welcoming and the same as home, I sort of feel like I come from there.

For me, this trip was how I imagine it would be to meet your extended biological family 39 years after you were adopted. You would see yourself reflected in strangers' faces. It would seem peculiarly familiar and foreign at the same time. I felt in many ways exposed. What my family had kept in the privacy of our homes – language, food, and all our special Finnish artefacts – were laid out for all to see in every home, street and shop. It was not different or special, it was just normal life. Like the migrants who shared their stories with me prior to the trip, I have a great love for Finland and all things Finnish but New Zealand is my home. It is great to be a New Zealander with a Finnish heritage. One Finn who migrated to New Zealand as a child told me “I am really proud of the fact that we are different – it is good to be different.” It was good and special to be different, not exactly a Finn and not exactly a Kiwi, but something new and unique.

7 Great grandmother

8 Great grandfather

Mummu used to make me rye crisp bread with cheese for lunch instead of marmite and chip sandwiches. I used to eat pulla⁹ soaked in milky coffee for breakfast. We had Joulu Pukki¹⁰ and presents on Christmas Eve. We listened to Finnish music and Pappa sometimes whirled Mummu around the lounge - they were beautiful dancers. We had our own language and we were proud to be Finns. There were lots of Finns in Kawerau where I grew up. While the immediate family took precedence, the extended community came together to celebrate and grieve the important milestones of Finnish community life. All my life people have said how lucky I was to have such a close-knit family. We talked almost every day and geography did not separate us. Our lives were inextricably entwined and we were somewhat matrifocal¹¹, probably due to the predominance of women across the current four generations. My Mummu's mother and father died within weeks of each other when she was nine. War and hard times orphaned her from her brothers and sister. Through her influence we were taught that there was nothing more important than family and the matriarchal thread pulled tight.

1.2. Key Terms

The key term 'Finn' refers to a native or inhabitant of Finland (Ollila, 1998; Sovijarvi, 2005), or to describe people who identify themselves as Finns, giving them the honour of expressing their self-perceived ethnic identity. I use the term 'Finnish-born' where required for clarity or analysis. The term 'Kiwi' is the common nickname, nationally and internationally, to describe a New Zealander. Although the denonym is New Zealander, Kiwi is used in this thesis to describe people who self-identify as Kiwis as distinct from New Zealanders. Again, this gives people the honour of expressing their self-perceived ethnic identity, or their sense of belonging, regardless of legal status or birthplace. The term 'Maori' refers to the indigenous Polynesian people of New Zealand, and the term 'Pakeha' is a common and popular Maori language term for New Zealanders who are considered to be predominantly of European descent.

I have adopted Sundborn's (2006) classification, using birthplace and length of residence in New Zealand, as markers for immigration. This approach is also supported by an OECD (2008, p. 11) report which found that that: "In settlement countries (Australia, Canada, New Zealand, United States), immigrants are considered to be persons who are 'foreign-born', that is, those who at some stage immigrated into the country of residence". The International Organisation for Migration (2003, p. 4) defined migration as: "...the movement of a person or group of persons from one geographical unit to

9 Pulla – Finnish coffee bread

10 Joulu Pukki – Father Christmas

11 A woman-centred or woman-dominated family (Ember, Ember, & Skoggard, 2005)

another, across an administrative or political border, wishing to settle indefinitely or temporarily in a place other than their place of origin”. I have adopted this definition and have used the term ‘migrant’ as a generic description, but also have used the terms ‘immigrant’ or ‘emigrant’ where required if a clarification of directionality of movement between countries is useful. I think of migrants in the context of this study as people who have voluntarily moved from one country to another to seek a better life, and for whom there are no legal obstacles preventing their return to their country of origin should they so desire.

When I commenced interviewing, I described the study participants as either first, second or third generation migrants. I was challenged on this categorisation by the participants who were children / teenagers when they migrated to New Zealand with their parents. They saw themselves as first generation migrants, because they had been born in Finland. For clarity, and with their permission, the participants are now described as either: Gen1 (first generation, born in Finland and migrated as adults), Gen1.5 (one-point-five generation born in Finland and migrated as children/teenagers with their parents), or Gen2 (second generation born in New Zealand to at least one Finnish-born parent). This recognises both migrant status and generational placement. Ruben Rumbaut coined the term ‘one-and-a-half generation’ to describe children who migrate and who span both the old and new countries but are not fully part of either (Perez-Firmat, 1994; Rumbaut, 1991; Zhou, 1997). Zhou (1997) commented that sometimes researchers break down the one-and-a-half generation into the two cohorts of 6-13 years of age and 13-17 years of age to take account of their physical and psychological development stages, their socialisation processes in the family, school, society and their orientation toward their homeland. A discussion of Gen1.5 by age at migration is referred to in the findings. The general approach to categorisation by generation reflects both genealogical rank in a kinship system (i.e., parents and descendants) as well as distance from Finland (Foner & Dreby, 2011).

Finally, throughout this thesis I refer to the names Pappa and Mummu. Pappa is one Finnish name for grandfather. There are others. For example, my children call my grandfather Pappa vaari which is a provincial name for grandfather or great-grandfather. Mummu is one Finnish name for grandmother. My family call my grandmother Mummu or Iso Mummu, which literally means big Mummu or great grandmother (ironic as she has the smallest physical stature in the family!). I also often refer to pulla, which is sweet Finnish coffee bread, of which there are many variations. Pulla is a regular staple in many Finnish homes and as I write this I can smell the yeasty cinnamon warmth that has been a constant presence all my life.

1.3. Aims of the Thesis

This study set out to answer the question: What are the health understandings and practices of a Finnish migrant group and their descendants in New Zealand, what has influenced these understandings and practices, and how have these developed and changed over three generations? The main research procedures were participant observation and in-depth interviews with 25 participants across three generations, utilising ethnographic and narrative methodologies. Data were analysed using both general inductive and narrative approaches within the theoretical frame of habitus (Bourdieu, 1999).

The specific objectives of the thesis were to:

- discover the migration and health experiences of three generations of a group with a shared Finnish migrant history resident in the Bay of Plenty
- investigate the influence of life experiences (such as migration and policy) on patterns of thinking and acting with regards to health
- investigate evidence of generational change

1.4. Structure of the Thesis

The structure of the thesis reflects the narrative foundations of the study as it tells the story of a group of people in New Zealand, with each chapter building on the one before. This introductory chapter situated the study in the field of community health within the context of migration, revealed my motivations for pursuing this research, and orientated the reader to the thesis. The next chapter explores the largely unstructured field of community health through a review of theory and published research, identifying the contribution this study can make within the theoretical constructs of narrative and habitus. A research paradigm and structure capable of supporting this contribution is investigated in Chapter Three, describing a qualitative research design within an interpretive paradigm. This chapter also reveals the 'hybrid' nature of study in the application of anthropological approaches within the discipline of community health.

Chapter Four explores a policy dimension with an investigation of the influence of government and company policy across the generations on the fields of migration and health. The next chapter explores the experience of migration across generations through the stories of participants, and investigates

whether these experiences have influenced patterns of thinking and acting with regards to health. The embodied nature of food as a key influencing symbol is explored in Chapter Six. Chapter Seven presents a generational lay model of health that participants' used to explain health maintenance, the reasons for good and ill-health, and influence their health keeping practices. Finally, Chapter Eight builds on previous chapters by deeply exploring how the participants' health and illness narratives reflect their wider life circumstances and experiences, providing a highly textured view of their field of health. Chapter Nine brings the thesis to a close with the conclusions and recommendations of the study.

Chapter 2. Exploring the Field

My curiosity about the health, migrant and policy experiences of the Kawerau Finnish community, and how these changed across the generations, suggested how I might approach the significant body of theoretical literature on the concept of health. In this chapter the field of community health is explored by examining current theoretical approaches to health through a review of published research, and identifying the contribution this study can make to understanding how people think, feel and act with regards to health. The field of community health (within the interest area of what people think, feel and do about health) was not particularly well established and the primary purpose of this chapter was to bring together a field to provide a theoretical base for the research (as opposed to a critique of an established body of knowledge) that supports achievement of the thesis objectives.

The review commences by analysing the various ways in which health is conceived and represented through lay models. Given the conceptual nature of health, literature on narrative is reviewed as a possible mechanism to explore understandings of health and patterns of behaviour. Finally, Bourdieu's (1990b, 1999) theory of habitus and the notion of culture are investigated for suitability as theoretical constructs with which to explore the multidimensional nature of health in a multigenerational context.

2.1. The Complex Mirage of Health

I commenced this research by searching for a simple definition of health. My search revealed that the meaning of health is anything but simple, and is instead a complex and dynamic concept that has many dimensions. This research adds a further dimension within a multicultural context, and highlights how understandings of health defy simple homogenous categorisation (Chapters Six and Seven), encompass wider structural components (Chapters Four, Five and Eight) and can influence health behaviour (Chapter Seven), particularly when wider factors are taken into account.

The meaning of health has a long history: from Hippocrates' concept of health being an illness-free state in the 5th century BC (on which modern biomedicine is based); to the World Health Organisation definition, which expanded on the biomedical paradigm, to include social and emotional well-being; to religious, spiritual and supernatural components from Pacific, Asian and African cultures; and more recently, encompassing wider structural components such as the social, political and economic aspects of peoples' lives (Weerasinghe & Mitchell, 2007). Many have attempted to provide an all-

encompassing definition of health. Health has several dimensions and a number of studies find that health is a complex concept that has different meanings to different people, and these meanings are subject to change. These diverse meanings are also embedded within complex economic, social, cultural and political processes e.g., (Ailinger & Causey, 1995; Dorazio-Migilore, Migliore, & Anderson, 2005; Good, 1994; S Heistaro, 2002; Kenney, 1992; Laffrey, 1986; Larson, 1999; Meleis, 1990; Saylor, 2004; Woods et al., 1988) and: "...any naïve application of this concept to clinical practice is riddled with pitfalls" (Dorazio-Migilore et al., 2005, p. 340). This complexity is described by Dubos (1961) as a receding mirage where, from a distance, the concept of health appears clear, but as you get closer the clarity ebbs away. This complexity can breed disagreement as attempts are made to define health from various perspectives including medical, social, spiritual, economic, and others.

The medical model appeared dominant in literature, policy and in the everyday lives of the research participants in both Finland and New Zealand. Larson (1999, p. 124) asserted that: "The medical model is the most widely used conceptualisation in medical research" and that this model is encapsulated in the enduring World Health Organisation (WHO) definition of health as: "...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organisation, 1946). This etic¹² conceptualisation has an individual focus on physical and mental health with its roots in the scientific paradigm, where the body is viewed as machine-like (Larson, 1999). Saylor (2004, p. 99) explained that:

Current health definitions and models often reflect the dualistic Cartesian philosophy underlying the medical model that the mind and body represent different functioning systems. As such, the models represent a Western view of health and illness, that divides health into distinct components (e.g., physical, emotional and social).

The concept of mind-body dualism is shaped by the biomedical worldview, where the physical is seen as separate from the human being (mind and soul), and the prime focus is on the sick individual as opposed to the wider family or society (Helman, 2007). The medical model assumes that diseases are universal biological entities. These disease entities produce symptoms that can be measured through clinical or laboratory testing, as opposed to the patient experience of the symptom which is often shrouded in cultural language. Within this model, the role of the clinician is to interpret symptoms and

¹² Emic and etic models provide one way to view health and illness through a cultural frame. Barnard and Spencer (1998, p. 180) define an emic model as "one which explains the ideology or behaviour of members of a culture according to indigenous definitions" and an etic model as "one which is based on criteria from outside a particular culture. Etic models are held to be universal; emic models are culture-specific".

de-code cultural language in order to discover the underlying biological disturbance so that empirical / rational treatment can be applied. If a person's complaint reflects subjective perceptions and not a physiological condition, then the meaningfulness of that complaint is called into question (Good, 1994). While the seemingly homogenous biomedical model is not uniformly practiced, it is reasonable to generalise that there may be a gap between what biomedical health professionals (in their professional capacity), understand about health and illness, and what patients understand about health and illness, as revealed by their lay models (see section 2.2 below). This gap can be even more apparent in multicultural communities where cultural diversity exists (Helman, 2007; Pool & Geissler, 2005).

While biomedicine or the medical model is often referenced in homogenous terms, it is more heterogeneous in nature, and is wider than hospital medicine including various subcultures such as rural and family medicine. Various subcultures also exist within hospital medicine, for example the idea that surgeons 'cut' and physicians 'feed'. In addition, each health profession can be thought of as having its own culture developed through education and socialisation. Differences also exist across countries, for example, a medical practitioner acculturated in the United Kingdom would have a different subculture to one acculturated in the United States of America. More importantly, even those health professionals drawn from a population or a community do, through their educational and socialisation experience, become different from the source community or 'enculturated' with a 'medical gaze'.

Critics of medical models propose that disease is more than simply biological, and that economic and social factors must also be taken into account. Critics also raise the issue that people can be unwell without having a diagnosed disease, or, people can have a disease without feeling unwell, and medical models cannot account for this complexity (Larson, 1999). Despite the criticisms, medical models have been responsible for spectacular advances in medical research, and they continue to dominate health care in so-named Western societies. Other models also exist and, like medical models, have an individual focus. For example, the wellness model makes a link between the mind and the body, proposing that the mind can affect even the most basic of physical processes, such as the digestion of food. The environmental model has a focus on the ability of the individual to adapt to all aspects of the environment, including the physical, emotional and social. Health is achieved, in this model, when the individual is successful in adapting to their environmental circumstances (Larson, 1999).

Various concepts of health are frequently grouped into either Western or non-Western categories, which are then often referenced as mutually exclusive and homogenous. However, in practice, the categories can be blurred with peoples' understandings reflecting a mix of both. Further blurring occurs within the categories, as both are heterogeneous in their own right; not every Western conception or lay model of health is the same, even if there are similarities. Worsley (1982, p. 315), in referring to formal (as opposed to lay) health systems, critiques the validity of the Western / Non-Western categorisation, stating that:

First, "non-Western" is a dubious concept because, historically, Western medicine has long influenced large regions outside the West, notably Asia and the Americas, and because interchange between these cultural areas (not all one-way) is increasing in scale and intensity at an exponential rate. Further, the category "non-Western" is either an arrogant, residual ethnocentrism – merely meaning "not like us" – that has no place in anthropology, or, if it implies that there is something in common between all such systems, is doubly wrong.

One definition of Western medicine is: "A system in which medical doctors and other healthcare professionals (such as nurses, pharmacists and therapists) treat symptoms and diseases using drugs, radiation, or surgery. It is also called conventional medicine, mainstream medicine, orthodox medicine, biomedicine and allopathic medicine ("The University of Texas: Anderson Cancer Centre," 2010). The focus of Western medicine is on controlling the body and keeping it from descending into the chaos and disorder imposed by disease. There is an expectation in this paradigm in modern times that death does not necessarily follow disease, and that when disease presents itself help will be forthcoming from medical science (Lupton, 2003). Western conceptions of health tend to favour biological concepts such as genetics, particularly in the case of mental health, and people in the West tend to seek concrete explanations for illness (Swami et al., 2009). The medical model is frequently referred to in the Western or European policy setting (Balint, Buchanan, & Dequeker, 2006) and is a model where disease is viewed as separate from the person suffering the disease (McWhinney, 1988).

A non-Western conception of health is generally referred to as broader than the biological, often includes aspects of spirituality and the idea of balance, and is a descriptor applied to health conceptions that are not categorised as Western. For example, in research exploring barriers experienced by refugees in accessing New Zealand health services, Lawrence (2003) found:

...differing cultural understandings of health and illness were particularly evident in terms of mental health. Medical practitioners noted how refugees commonly present with somatic complaints such as body ache, tingling and one-sided body pain...ideas held by refugees about mental health are quite different from the Western medical model...Unlike in Western culture, there are no shades of grey between being mentally sound or psychiatrically unwell (2007, p. 217).

Although there is recognition in the literature of the complexity of health concepts, there is nevertheless a tendency to continue to categorise as conforming to either the Western or non-Western conceptions, and to assume an individual focus. There is a difference between the largely policy or biomedically-constructed conceptions of health as Western or Non-Western, and understandings that are revealed through 'sense-making' (Harter, Japp, & Beck, 2005), or the process by which lay people give meaning to experience. The resultant lay models of health reflect the diversity one would expect in the complexity and multi-dimensional arena of community health (revealed in Chapter Eight). Notably there is less research interest into the Pakeha/European perspective; perhaps revealing an assumption those groups in New Zealand who are not Maori, Pacific, Asian or refugees would reflect the dominant Western/biomedical model of health.

Definitions of health and illness vary, sometimes widely, between groups as well as individuals. However, health and illness is usually understood to be wider than disease or a set of physical symptoms (Helman, 2007; Weiss, 2001; Winkelman, 2009). Eisenberg (1977) provided a disease/illness definition for medical anthropology, with 'disease' being the measurable identification of a bodily disorder from the biomedical perspective, and 'illness' being the patient's experiential awareness and understanding; doctors diagnose and treat disease and patients suffer illness. Cassell (1976, p. 48) proposed that: "...illness is what the patient feels when he goes to the doctor, disease is what he has on the way home". Disease is what the doctor names an illness, but concepts of illness are informed by multidimensional factors, including the wider culturally-informed notion about the nature of adversity. The experience of being unwell is subjective and is informed by a person's health worldview about why they are unwell, and what action they believe they should take to remedy the illness. A similar distinction can be made between cure and healing:

...doctors may cure disease, but that does not necessarily mean that the patient's illness is healed. Cure implies the absence of disease, or its expulsion from the body, whereas healing refers to the improvement of the ailing body and the wellbeing of the ill person (Pool & Geissler, 2005, p. 54).

This research contributes to the body of literature in New Zealand that reflect the complex, multidimensional and heterogeneous nature of health, both between and within various groups such as Maori, Pacific, Pakeha/European, Asian and various refugee groups. Each of these groups is diverse and this diversity is reflected in their meanings of health. Pacific, for example, comprises multiple linguistic and cultural groups. This study explores the notion that the seemingly homogenous group of Pakeha/European also comprises multiple linguistic and cultural groups, each with their own complex conception of health and unique socio-cultural circumstances. Therefore, one might expect diversity to be reflected in their meanings of health also.

Health is understood by various groups in New Zealand to include physical, mental, spiritual and emotional aspects. For example, the worldview documented by Mason Durie in 1985 provides one summary of the Maori health perspective that is often referenced: te Whare tapa whā. Health is viewed as having four dimensions: te taha wairua (a spiritual dimension), te taha hinengaro (a psychic dimension), te taha tinana (a bodily dimension), te taha whanau (a family dimension) (Durie, 1985). In her report on the health perceptions of Maori Women, Murchie (1984, p. 81) found that health: "...is more than the normal functioning of the human body, is a concept much older than modern medicine" and is: "...a healthy mind in a healthy body". She proposed the Maori concept of tapu is: "...a manifestation of the effect of attitude and belief upon a person in good physical health" and that: "Today there is an increasing acknowledgement that the health of the individual, and ultimately of society, mirrors a complex relationship of physical, mental, spiritual, social, political and environmental factors" (Murchie, 1984, p. 81). A literature review of the health beliefs characteristic of Polynesia revealed the place of spirituality and religion in health and illness causation (Capstick, Norris, Sopoaga, & Tobata, 2009) (see also (Butt, 2002; McGrath, 1999)). In their 1987 study of the health-keeping practices of Pakeha women in central Auckland, Chambers and Macdonald (1987) found that: the women conceived of health as a multifaceted state of well-being including social, mental, spiritual and/or emotional aspects (see also (Koops, 1996) for similar findings).

Health is also understood by various groups to be affected by wider influences such as political, community, environmental, economic, social and cultural characteristics. For example, a number of studies found that for Samoans, illness is seen as an inevitable, though potent, disruption to life and social systems (Capstick et al., 2009; Drummond & Va'ai-Wells, 2004; Kinloch, 1985) and in Polynesian languages there are no words equivalent to the biomedical concepts of 'health' or 'disease'. Samoans in New Zealand draw on both traditional and Western models of treatment and healing

resources (Norris, Fa'alau, Va'ai, Churchwood, & Arroll, 2009). Pacific ideas of health are closely linked to cultural identity and a sense of self, informed by a collective based culture (Capstick et al., 2009; McMullin, 2005; Tamasese, Peteru, Waldegrave, & Bush, 2005). The holistic Maori health worldview includes the community, environment, importance of elders and a focus on traditional healing and traditional cultural practices (Durie, 1985). In their study of pregnancy planning by mothers of Pacific infants, Paterson et al (2004, p. 1-2) noted evidence that: "...Pacific women in New Zealand have the highest rate of unplanned pregnancies and abortions across all age groups, with a high number of hospitalisations of Pacific women due to pregnancy, childbirth and health services relating to reproduction". They went on to link this to cultural mores regarding sexuality:

Within Pacific communities, cultural mores are likely to be the biggest obstacle to effective family planning...Pacific people regard sexuality and contraception as subjects not spoken of in the home. There is no word for sex in some Pacific languages, a very strong message of no sex before marriage, and women are not encouraged to use contraception.

A study of young Pakeha men's conceptions of health concluded that the concepts of health, illness and health care were fluid for this group and were:

...difficult to isolate from day-to-day life, an individual's past, biological reality (such as degree of health, injury or illness), and his predictions of the future. Because of this, concepts of health, illness and health care cannot be explored in any detail without referring to the context in which individuals are discussing or experiencing them (O'Connor, 2002, p. 139)

The Asian Health Chart Book found that Asian New Zealanders differed widely in language, culture and settlement history and that this heterogeneity could affect their health needs. The document also found that ethnicity and migrant status must be taken into account when assessing health status in addition to other factors such as age, gender and social class (Ministry of Health, 2006). In her study of the lived experiences of Somali refugees in New Zealand, Lawrence (2007) found that Somali health beliefs and practices are heavily influenced by Islamic teachings and Western medicine, and that Somali notions of health and disease were strongly influenced by the social, economic and political contexts in which they were situated. North (1995) found that Cambodian refugees living in Palmerston North suffered from illnesses for which no biomedical explanation could be found, and that in these circumstances they offered explanations themselves drawing from Cambodian theories of illness as well as personal life experiences. Through this process, they developed a unique transitional system of healing which was appropriate to their transitional status from a refugee perspective.

A number of studies found that access to resources, including health care access and utilisation, were also important influencing factors on the health of individuals and groups in New Zealand. For example, referencing a number of studies, Ruwhiu et al (2008, p. 15) summarised that: “Mana Tangata identity reinforcing a sense of belonging has been described and recognised as a prerequisite and determinant of Maori health and wellbeing” and that: “...oscillations between secure and compromised identity are explained by a lack of meaningful access to cultural and physical resources...and any strategy promoting Maori health and wellbeing must account for, or at least consider, addressing this” (2008, p. 16). In her study of three generations of rural Maori women’s health practices, Prichard (1992) found that the women were pivotal in maintaining the health of their families as well as their own; there was a relationship between poverty and health and this influenced health-keeping practices in terms of a return to traditional Maori ways of keeping health, both because of the belief that the medicines were not harmful and because they provided a cheap alternative; the women felt powerless in many aspects of their lives including lacking the ‘willpower’ to give up smoking; and the women were not assertive in asking for preventative care. In their study of the illness and medication beliefs of European and Tongan people with diabetes in New Zealand, Barnes et al (2004, p. 1) summarised that studies found that a number of barriers such as cost, lack of knowledge, and limited access to and utilisation of healthcare contributed to the high incidence of diabetes in Pacific Island people. In her thesis on Indian, Korean and Chinese immigrant communities in Auckland, Anderson (2007) found that: “Their understandings of health and health seeking behaviour were affected by previous experiences with health care systems, structural barriers such as language and lack of health care professionals, and social networks” (Anderson, 2007, p. 90).

2.2. Lay Models of Health

Lay models of health give shape to meanings of health that are complex, dynamic, multidimensional, and can influence health behaviour (including the behaviour of health care professionals). Despite their limitations, lay models are useful when wider influencing factors are taken into account. Referencing a number of studies, Swami et al (2009, p. 519) (see also (Robertson, 2006)) summarised that:

Lay beliefs of health and illness are conceptual models used by individuals or communities of individuals to explain health maintenance and reasons for ill-health. Research on lay perceptions of health and illness is well established, with work stretching back over three decades. This body of work has consistently shown that lay people view health and illness as something integrated into daily life, fuelling a shift away from wholly bio-medical frameworks towards more holistic understandings of health and illness.

This research adds to the body on literature on lay models of health, revealing both generational aspects (Chapter Seven) and the influence of wider factors (Chapter Eight) such as migration (Chapter Five), policy (Chapter Four) and food capital (Chapter Six) in a multicultural context.

Lay models can influence the decision whether or not to seek health care, the kind of health care that is sought, the experience of receiving care, and how symptoms are experienced. Lay models of illness and treatment have been found to influence self-management of a range of chronic illnesses, as well as being strong predictors of medication adherence and therefore health outcomes (Barnes et al., 2004). Helman (2007, p. 146) proposed the following non-physiological factors that influence whether or not people seek medical care: "...availability of medical care, whether the patient can afford it, the failure or success of treatments within the popular or folk sectors, how the patient perceives the problem, how others around him or her perceive the problem". How a person perceives a health issue, including reproduction and conceptions of pain, is based on the person's particular lay model of health. This model is informed by both personal beliefs and the wider social and cultural circumstances that influence the person's life. Some have proposed that understandings about health could even influence the biological responses of our bodies (Barnes et al., 2004; Lock & Kaufert, 2001; Winkelman, 2009). From a biomedical perspective, symptoms could be explained in terms of physiological changes. However, symptoms and how people make sense of symptoms can be viewed as an interaction between cultural paradigms and embodied experience. Research on symptom perception found that: "...symptoms are not simply a matter of detection but are a perception relating to a range of psychological factors including mood and cognitions" (Pennebaker, 1983, p. 68) and that symptoms can vary across cultural, historical and time domains (Ogden, 2007).

While the word 'model' gives the impression of a systematic set of ideas, lay models are in fact highly individualistic and take into account each person's individual biological and socio-cultural circumstances and influences (Helman, 2007). For example, a study of Chinese migrant women in England found that the women drew on both Western and Chinese health care systems when seeking treatment, and that their decisions on which treatments to use were informed by their explanatory models (G. Green, Bradby, Chan, & Lee, 2006; Kleinman, 1980). In commenting on Zola's (1973) study of pathways to the doctor, Helman (2007, p. 147) concluded that it: "...illustrates that decisions to consult a doctor may be related to socio-cultural factors, such as the wider definitions of health, rather than to an illness's severity". He also proposed that people may not always identify symptoms with illness and therefore only seek medical help if the symptoms begin to interfere with daily living,

or as a result of pressure from family or friends to seek medical care. The same factors that influence the decision to seek medical care also influence what happens once people get to the doctor, and whether or not medical advice is complied with (Helman, 2007).

A body of research found that health professionals and patients have varying understandings about health and illness and that: "...patient and physician interpretations of disease are often quite dissimilar, and may affect the quality of care a patient receives" (Gregg & Saha, 2006b, p. 543), see also Swami et al (2009). A central idea in this thesis is that there is a difference between how health professionals view health (with all their biomedical diversity), and lay concepts of health that are revealed through a process of 'sense-making'. This difference could compromise care, but may be able to be bridged through narrative (see Section 2.4 below). Van Dellen et al (2008, p. 380) asserted that:

Patients' and families' explanatory models (Kleinman, 1980) vary accordingly to personality and socio-cultural factors. In a multi-ethnic society, it is becoming increasingly significant that doctors understand the different beliefs of their patients in order to improve patient/doctor communication as well as patient adherence to treatment.

Lupton (2003, p. 108) proposed that well-established lay models "...may underlie patients' refusal to comply to doctors' instructions and contribute to misunderstandings between doctor and patient if the former is not aware of the existence of these beliefs". The Medical Council of New Zealand recognised this, and advised that:

Beliefs and values, and cultural and religious practices are central to the lives of doctors and patients. All doctors have personal beliefs that affect their day-to-day practice. Some doctors' personal beliefs may give rise to concerns about carrying out or recommending particular procedures for patients. Patients' personal beliefs may be fundamental to their sense of well-being and could help them to cope with pain or other negative aspects of illness or treatment. Personal beliefs may also lead patients to ask for procedures that others may not feel are in their best clinical interests, or to refuse treatment (Medical Council of New Zealand, 2009).

Health professionals and patients may hold different lay models of health, and this may impact the quality of care they receive. A number of studies found conflicts in conceptions of health between

health professionals and immigrants (Kagawa-Singer & Kassim-Lakha, 2003; Weerasinghe & Mitchell, 2007). For example, Reiff et al (1999, p. 1814) reported that:

Immigrants throughout the world commonly report feeling misunderstood by their doctors. This perceived communication gap between immigrants and doctors refers not only to language barriers but also to differences in defining illness and in beliefs about health.

Even if health professionals and their patients come from the same social and cultural background, they may have different understandings about health that spring from their own experiences, as well as their professional training. Biomedical doctors, for example, have been said to have their own ‘subculture’ – a biomedical worldview that they have been ‘enculturated’ into through their professional training and practice. Within this view, doctors search for ‘real’ explanations for illness based on scientific rationality, and for physical explanations for illness that can be measured, tested for and ‘proven’. This arguably reductionist¹³ search for physical evidence of illness, results in treatments such as surgery or the administration of pharmaceuticals. This can result in hegemony where the biomedical physician rejects lay interpretations of illness on the basis that only the biomedical view is objective and scientific (Pool & Geissler, 2005).

It is proposed that one of the reasons for this is that medical students learn to ‘see’ in a new way through their training, developing a ‘medical gaze’ early on; they develop the skills of seeing a person anatomically as opposed to personally (Good, 1994). Good (1994, p. 70) reflected that:

Over and over again I have been struck by the enormous power of the idea within medicine that disease is fundamentally, even exclusively, biological. Not that experiential or behavioural matters are ignored, certainly not by good clinicians, but these are matters separate from the real object of medical practice.

Taylor (2003, p. 559) held a similar view, arguing that medicine:

...sees itself as a “culture of no culture”, and its practitioners tend systematically to foster static and essentialist understandings of the “culture” of patients... To change this situation will require challenging the tendency to assume that “real” and “cultural” must be mutually exclusive terms. Physicians’ medical knowledge is no less cultural for being real, just as patients’ lived experiences and perspectives are no less real for being cultural.

¹³ Reductionism is the notion that complex phenomena can be explained by reducing them to some more basic level; for example the idea that disease is basically the physical malfunctioning of organs and cells (Pool & Geissler, 2005).

Many studies find that it is important to understand that conceptions of health of the health professional and the patient may be different, and that understanding this difference is important for provision of appropriate care. For example, in discussing the conceptions of health of older Hispanics in the United States of America, Ailinger and Causey (1995, p. 605) asserted that: “Although nurses are socialised to various concepts of health early in their professional education, nurses seldom consider that their clients’ health concept is culturally defined and may differ from their own”. Carrillo (1999, p. 829) advised that: “In today’s multicultural society, assuring quality health care for all persons requires that physicians understand how each patient’s socio-cultural background affects his or her health beliefs and behaviours”, and this can include the influence of religious beliefs (Mir & Sheikh, 2010).

Other studies find that it is important for health professionals to not only have an understanding of lay conceptions of health, but also to have an appreciation for the history and identity of their patients. In her study of older mixed ancestry Asian Americans, Tashiro (2006) found that despite diversity in the participant group, an association between identity, health practices and how participants experienced encounters with the health care system persisted. She also found that the stronger the association with their Asian identity, the more likely they were to rely on traditional health methods, if they had been exposed to them, and that sharing a similar ‘racial’ background was of little predictive value in terms of health beliefs, practices and interpretations of experiences with the health care system. She proposed that her study: “...shows the importance of the context of people’s lives; of history, place and social experiences that shape the meaning given to encounters that health providers might consider routine” and that: “It alerts us to the fact that the people health providers encounter in practice are constantly making meaning out of their experiences through the prisms of their histories and identities” (2006, p. 48).

Lay models are shaped by socio-cultural factors including inherited folklore and, particularly in industrialised nations, concepts put forward by the media, internet and biomedical models. The migration experience is found by a number of studies to be part of the multi-causal nature of lay models, particularly where the experience has been traumatic (Meadows, Thurston, & Melton, 2001; Svenberg, Mattsson, & Skott, 2009; Whitley, Kirmayer, & Groleau, 2006). Young (1976, p. 147) suggested that: “Particular beliefs about sickness and health persist because people find them useful and convincing” and Lupton (2003, p. 108) summarised that:

Most individuals develop health beliefs derived from folk-models of illness, alternative forms of medical practice, the mass media and ‘common sense’ understandings derived from personal

experience or from consultation with friends and family, and continue to subscribe to these beliefs while consuming orthodox health care.

However, Fuchs (2009, p. 1-2) suggested that the word ‘belief’ evokes images of religion and faith and that:

At the same time, when applying the word to someone, a sense of scepticism and ontological doubt is evoked. To say that someone believes something is to emphasise that a person lacks proof of this ‘something’. It suggests that he or she relies on personal judgement, if not on someone else’s personal authority, or some institutional authority, when stating that something is the case or does exist, or that one thinks it is likely that it exists. Belief thus refers to the presuppositions an individual or a social group have. Simultaneously and intrinsically related though, are the presuppositions of the person observing, listening and commenting.

This elucidates the tension between biomedical belief systems, which are based primarily on empirical knowledge, and ‘other’ belief systems. While these belief systems are not mutually exclusive, neither are they equivalent. As well as tensions there are dangers and difficulties in attempting to represent the beliefs of ‘others’; partly because we do not have direct access to people’s beliefs, and partly because there are differences between practising something and talking about practising something (Fuchs, 2009). Referencing the thinking of Geertz, Herzfeld and Bourdieu, Fuchs (2009, p. 6) commented that: “Talking about the inner or embodied beliefs of others...affirms their non-reducible character”. Neither does knowledge equate directly with beliefs. “Different knowledges and beliefs, or knowledge and belief systems, achieve different things” and: “...they work from different ontological and epistemological assumptions” (Fuchs, 2009, p. 8). The concept of belief as an appropriate frame for analysis of health and illness narratives has been challenged on theoretical grounds, with the main criticism being that a concept of belief that privileges the knowledge of the researcher over the participant is open to epistemological criticism (Pool & Geissler, 2005). Good (1994, p. 112) cautioned that: “...a system of medical knowledge and the practices through which it is reproduced, elaborated, and applied are interrelated in ways far more complex than those suggested by belief and behaviour models”. This study does not simply attempt to find ‘beliefs out there’, but rather acknowledges: “...the existence of several layers of meaning of assumptions, presuppositions and dispositions, of replies to doubts, convictions and aprioris” among the participant group “...which all in different ways, and varying according to context, inform or not inform – but definitely do not determine – social practices” (Fuchs, 2009, p. 12).

Kleinman (1980, p. 26) proposed that a: "...health care system includes people's beliefs (largely tacit and unaware of the system as a whole) and patterns of behaviour. Those beliefs and behaviours are governed by cultural rules". Beliefs, therefore, are for the most part unspoken, deeply embedded in the cultural realm, and somewhat oblivious of the health care system. Kleinman's (1980) explanatory models provide cognitive approaches to illness within the interpretive paradigm, with the aim of looking at how illness is patterned, interpreted and treated. The models utilise concepts of illness with a focus on what people perceive the causes of their illness to be, as opposed to the biomedically defined disease based on a physiological pathology. Helman (2007, p. 127) suggested that: "...on an individual level, the process of defining oneself as being 'ill' can be based on one's own perceptions, on the perceptions of others, or on both" and that: "...having one or more abnormal changes of symptoms may...not be enough to label oneself as being 'ill'". He also proposed that socio-cultural factors determine perceptions of illness through a 'language of distress' that bridges the gap between the subjective experiences of illness and the social acknowledgement of those experiences.

Explanatory models (Kleinman, 1980, 1988) provide conceptual templates for patients and healthcare practitioners to have the 'disease/illness' discussion. Etkin et al (2008, p. 56) proposed that explanatory models: "...identify how a particular illness comes about and describe the progression of symptoms and prognosis. These models provide the integral framework for health knowledge and point the direction for the prevention and resolution of illness". Explanatory models can also be shaped by heuristics; people engage in problem solving, discovery and learning based on their experiences, such as the previous experience of an illness event, as well as their access to the experiences of others, and public meta data of illness and health. While the concept of explanatory models sought to bridge the disease/illness divide with a view to providing 'culturally appropriate' biomedical treatment, it generally did not take into account the wider social influences on health such as relationships, social processes and meanings. Inclusion of these wider influences could be one avenue for further development of explanatory models. A criticism is that current models assume patients only have one type of knowledge about their illness, and a limitation of current models is that they are applied to an episode of illness as opposed to the wider illness experience. Young (1982) posited that: "...we should take the wider social relations beyond the individual into account when studying sickness, and that there should be more focus on the social conditions of (medical) knowledge production".

Lay models are influenced by understandings about the origin of misfortune in general, and understandings about the biology of the body and the ways in which it can malfunction. Helman (2007) described four lay theories of illness causation as: within the *individual*, in the *natural world*, in the *social world*, and in the *supernatural world*. Helman (2007, p. 135) stated that:

Lay theory that locates the origin of ill health with the *individual* deals mainly with malfunctions within the body, sometimes related to changes in diet or behaviour. Here the responsibility for illness falls mainly (though not completely) on the patients themselves.

He further commented that this theory is particularly common in Western / industrialised nations where public health campaigns are based on the premise that unhealthy personal behaviours result in ill health. Crawford (2006) described this as ‘healthism’, a political ideology which emerged in the United State of America in the 1970s which situated the problem of health and disease at the level of the individual. This ideology has been used with pejorative intent, blaming individuals for illness and informing public health campaigns for ‘healthy lifestyles’, and also as an empowering phenomenon with the popular media-driven uptake of preventative medicine, yoga, meditation, fitness regimes, diets and the emphasis on lifestyle changes, particularly in so-named Western societies. Other ‘incorrect’ behaviours such as sitting in a draught can also result in illness in the individual lay theory of illness causation, as can: a ‘wrong’ diet, personal carelessness resulting in accidents or injury, self-inflicted injury such as suicide, and allowing negative feelings and emotional states to persist in your life (Helman, 2007). If one has become ill, according to this lay theory, it is one’s own fault and one should have: eaten differently, behaved differently, or kept your emotions in check.

Helman (2007) proposed that this theory is more often prevalent in groups who have socio-economic control over their lives and accept responsibility for ill health causation, as opposed to groups that perceive themselves as socially and economically powerless victims of circumstances over which they have no control, and feel little responsibility. According to Helman (2007), some origins of ill health are believed to be within the body but outside of the person’s conscious control including personal and physical vulnerabilities. Personal vulnerabilities include psychological, genetic or hereditary traits such as being nervous or easily worried. Physical vulnerabilities include the idea that some people, and even families, are born naturally less resistant to illness than others, and that environmental circumstances such as living in a cold climate, can create physical vulnerability. According to this theory, both personal and physical vulnerabilities can be mitigated through personal endeavour such as diet, exercise and resisting emotional tendencies (Helman, 2007).

The lay theory that locates the origin of ill health within the *natural world* relates illness to climatic conditions such as excess cold, heat, sunlight, wind, rain, snow or damp as well as natural climatic disasters such as tornadoes and storms. Possible influencing factors on health in this aetiology include the moon, sun and planets, injuries caused by animals and birds, infections caused by germs, bugs or viruses, and environmental elements such as air, climate and the seasons. The ostensible father of clinical medicine, Hippocrates, proposed that physical illness would result if any of the four bodily fluids (or humours) were out of balance. Humoral imbalance was also thought to lead to chronic emotional states i.e., black bile leading to sorrow (Salovey, Rothman, Detweiler, & Steward, 2000). The Greek humoral medical system has some elements in common with the natural world theory:

Humoral medical systems conceive the universe as made of basic opposing qualities – hot and cold, wet and dry, in the Greek system – and physiological functioning as a set of interactions among basic constituent “humours” – blood, phlegm, yellow bile, and black bile, in the Greek and Islamic case (Good, 1994, p. 101).

The humoral medical system, still prevalent in many countries, provided theory for modern clinical diagnostics and therapeutics. Good (1994, p. 108) explained that:

The process of digestion – the metamorphosis of food into blood and tissue through cooking produced by innate heat – and the opposite or negative transform of digestion – the rotting of food or the humours to produce morbid humours, which are inassimilable and which disperse the moisture of the body – provided the basic structure for all physiology theory in classical Gaelenic-Islamic medicine...Disease caused by the presence of a morbid humour is treated by evacuation of the abnormal matter. This may be accomplished through blood-letting, cupping with bleeding, leeches, purgation, emesis, cupping, enemas, sweating, and other less important therapeutic techniques.

In the *social world* aetiology ill health results from the personal malevolence of others enacted, either consciously or unconsciously, through witchcraft, sorcery, the ‘evil eye’ or by causing physical injuries such as poisoning or battle wounds. The *supernatural world* lay theory attributes ill health to the direct actions of supernatural entities such as gods, spirits or ancestors and includes possession by ‘disease spirits’. Illness is thought to be a divine punishment for personal transgressions and consequently, one can only be cured of an illness by being forgiven or making right the sin (Helman, 2007). Many of these theories emerge as a combination in practice and an example of this given by Helman (2007) is where a person might blame stress at work for causing a life imbalance, resulting in susceptibility to germs which make them sick, which causes them to have time off work.

Etkin, Baker and Busch (2008, p. 56) asserted that naturalistic explanatory models are: "...impersonal and find parallels in biomedicine, which understands disease causation to include pathogens, trauma, nutrient deficiencies, and other tangibles that can befall anyone" and that personalistic explanatory models describe: "...illness as attributed to some purposeful agent" and that the person who becomes ill is the: "...object of misfortune directed specifically against him for reasons that are relevant to him alone". Personalistic explanatory models look deeper for the causes of ill health and include beliefs that illness can be caused by the retribitional acts of the supernatural, or the supernatural invoked by humans. Naturalistic models look to the tangible environmental features that are believed to cause ill health such as: cold, wind, damp, the actions of body fluids, and contagion through contact with someone who is ill. These models focus on the contrast between two typologies. The difference in co-existing explanatory models gives rise to the concept of medical pluralism where there is more than one way to understand ill health, and more than one way to act in response to ill health (Helman, 2007; Winkelman, 2009). Swami et al (2009, p. 520) commented that:

...Eastern communities, particularly those from low socio-economic groups, appear to locate the origin of health and illness in the social (e.g. failure to observe social norms or perform essential rituals) or supernatural worlds (e.g. spirits and ghosts).

2.3. Health Behaviour

Lay models give shape to people's conceptions of health, and there is an association between these models and how people behave. For example, self-rated health has been found to correlate with social integration, mental stress at work, physical activity and level of educational achievement (Aromaa, Koskinen, & Huttunen, 1999; S Heistaro, 2002; S Heistaro, Jousilahti, Lahelma, Vartiainen, & Puska, 2001; Helakorpi, Uutela, Prattala, & Puska, 2002; Leiter et al., 1999; Pender, Walker, Sechrist, & Frank-Stromborg, 1990). Other studies have found that how a person judges their own health is a potent predictor of future mortality and morbidity, even after taking into account other factors such as socio-demographic, physical, and psycho-social health status (Abdulrahim & Ajrouch, 2010; Appels, Bosma, Grabauskas, Gostautas, & Sturmans, 1996; S Heistaro et al., 2001; Idler & Angel, 1990; Kaplan & Camacho, 1983; Laaksonen, Rahkonen, Martikainen, & Lahelma, 2006; Martikainen et al., 1999; Mossey & Shapiro, 1982; Naslindh-Ylispangar, 2008; Wallston, 1989). High self-esteem, a sense of optimism, as well as good self-rated health has been associated with positive health behaviour and conversely, bad self-rated health, low self-esteem and a negative disposition has been associated with negative health behaviour (Courtenay, 2003; Marks, Murray, Evans, & Willing, 1999; Weinstein, 1982). Physicians and psychotherapists have for many years recognised the link between

psychological and physical disorders, and: “There has been long recognition that an optimistic mind and exhilarated spirit accompany a healthy body” (Salovey et al., 2000, p. 117). This connection between mind and body is well documented in psychology literature which finds a link between belief systems which: “provide a baseline for the functioning brain upon which other variables act and have their effects” (Ray, 2004, p. 29). Put another way, health / illness is a result of the interaction of psychological, social and cultural factors with biochemistry and physiology (Ray, 2004).

Some researchers have proposed that personal attitudes are central in determining what action people will undertake to achieve health (Coates & Boore, 1995; Hubbard, 2007; Shiloh, Rashuk-Rosenthal, & Benyamini, 2002). Others have proposed that both conceptions of health and behaviours are influenced by gender, values and social experiences (Courtenay, 2000, 2003; Lash, Eisler, & Schulman, 1990; Marks et al., 1999; Naslindh-Ylispangar, 2008). Yet others have proposed that behaviour and perceptions of health are influenced by experiences and the environment. For example, in her study of the health perceptions of Mexican American women, Mendelson (2002, p. 210-211) found that “...one’s health perceptions rest below the surface, are moulded by experiences, and are reflected in actions”. Dyck (1992, p. 696) asserted that: “To understand a person’s behaviour, one must have knowledge of the environments from which the person came and the behaviour patterns encouraged by these environments”.

A philosophical extension of thinking about environment emerges in the concept of embodiment. Gronseth (2007, p. 28) proposed one definition of embodiment as: “...referr[ing] to daily practices and skills that are not activated at a level of discourse. Throughout childhood, socialization patterns for everyday practices are learnt and embodied through, for instance, bodily imitations and experiences”. The idea is that the way we behave is determined by more than what we believe or are told, it is also determined by the subtle teachings of the seemingly mundane everyday embodied experience of our immediate social environment. Bourdieu (1989) asserted this type of learning is made possible by the existence of structural consistency in patterns of knowledge that are both mental, and spatially embodied. From a cultural psychology perspective, Kitayama and Uskul (2011, p. 419) proposed a model of neuro-culture interaction which hypothesised that:

...the brain serves as a crucial site that accumulates effects of cultural experience, insofar as the neural connectivity is likely modified through sustained engagement in cultural practices. Thus, culture is “embrained”, and moreover, this process requires no cognitive mediation”.

Various models and theories of health behaviour have emerged substantially in the field of social psychology and have been applied to the public health practice of health promotion, aiming to develop effective interventions that promote health behaviour change. However, there are issues to consider when attempting to ‘correct’ understandings and behaviours. Good (1994, p. 39) asserted that: “...‘belief’ serves as an unexamined proxy for ‘culture’” and: “...‘belief’ typically marks the boundaries between lay or popular medical culture and scientific knowledge”. Good (1994) also proposed that lay beliefs are often viewed as false propositions when juxtaposed with medical knowledge; the implication being that any conceptions of health that do not concur with current biomedical knowledge must be ‘corrected’. As medical knowledge advances with alarming speed, we are privy to the inner workings of human biology with ever increasing accuracy. However, it is worth noting that accuracy or ‘truth’ is a situational concept in biomedicine – what was ‘true’ and ‘scientific’ yesterday may be challenged today with the advent of new discoveries and technologies. In tandem, therapeutics and technologies develop which extend the boundaries of human health and life. Along with these advancements the temptation has been to assume the primacy of medical knowledge, and to assume that if peoples’ conceptions of health aligned with medical knowledge (which is constantly being revised) then they would change their health behaviours for the better. Good (1994, p. 2) proposed that as a consequence of medical advancements: “...we face a moral imperative to share that knowledge, to provide public health information to those whose beliefs serve them poorly as a basis for healthy behaviour...” but cautioned that: “...it is difficult to avoid a strong conviction that our own system of knowledge reflects the natural order” (Good, 1994, p. 3).

Good (1994) likened the belief system of religious fundamentalism to health beliefs (where salvation follows from belief) asserting that a-religious scientists and policy makers also see benefit in people having ‘correct beliefs’. Until recently, it was thought that understanding health attitudes, values and beliefs, and the cultural factors that influenced them, meant that programmes could be designed to ‘correct’ any faulty beliefs with information, and thereby improve the health of a group. However, it has been recognised that beliefs do not always lead to behaviour, and therefore it is necessary to research behaviour as well as beliefs, as well as influencing factors such as cultural and socio-economic reasons (Coreil, 2008). In their study of Chinese-Canadians’ perspectives on health and fitness, for example, Lu, Sylvestre, Mclynychuk and Li (2008, p. 25) found that the adoption of so-called ‘Western’ health and fitness practices were not based on shifts in values and beliefs, but rather were: “...pragmatic choices based on convenience, social relations, and access to resources” and emphasised the importance of attending to actual health practices as a way of understanding how immigration may affect health behaviour and health status. Williams (1995) proposed that one of the most problematic

issues with the promotion of 'healthier' lifestyles, is the lack of a clear relationship between health beliefs and health behaviour and that: "Consequently, there has been a shift away from explaining behaviour in terms of 'health beliefs', towards understanding peoples' logic, knowledge and practices, grounded in the context of everyday life" (Wilson, 2010, p. 264).

A number of models and theories of health behaviour exist, notably the health belief model (M. Becker, 1974; M. Becker, Radius, & Rosenstock, 1978; Glanz, Marcus, & Rimer, 1997; Glanz, Rimer, & Lewis, 2002; Rosenstock, 1974), model of illness behaviour (Mechanic, 1986), theory of planned behaviour (I Ajzen, 1985; I Ajzen, 1991), trans-theoretical model (Prochaska & DiClemente, 1983), social learning theory, theory of reasoned action, stages of change model and the health action model (Baum, 2008). Baum (2008, p. 456) commented that a major limitation of these types of models is that they: "...pay scant attention to the social, economic and cultural environments in which people's behaviours occur". Baum is not the only critic. Lu, Sylvestre, Mclynychuk and Li (2008, p. 22-23) stated that although social-cognition explanatory models that link beliefs and behaviour are popular, they: "...have been challenged in terms of their ability to predict health behaviour, and the extent to which they reflect the cognitive processes that actually underlie health-related choices". Joseph et al (2009, p. 71S) found that: "...social context affects behaviour directly rather than exclusively through beliefs as behaviour theory implies and that understanding contextual influences, such as transculturation, points to different forms of intervention". Joseph et al (2009, p. 75S) also commented that while research finds that health and illness are conceived differently in different cultural and social groups, health behaviour research has not explored how social contexts shape meanings of health behaviour for diverse groups. They describe the inductive concept of social context which includes both cultural and social determinants of health and health care decision making as:

...the sociocultural forces that shape people's day-to-day experiences and that directly and indirectly affect health and behaviour. These forces include historical, political, and legal structures and processes (e.g., colonialism and migration), organisations and institutions (e.g., schools and health care clinics), and individual and personal trajectories (e.g., family, community). Notably these forces are co-constitutive, meaning they are formed in relation to each other (2009, p. 72S).

Burke et al (2009, p. 66S) linked social context to Bourdieu's (1989, 1990b) concept of habitus, proposing that:

...social context encompasses multiple realms including both cultural and social domains of influence, as illustrated in Bourdieu's concept of *habitus* (embodies history, presence of the past)...like *habitus* our concept of social context incorporates elements and processes that are outside conscious awareness.

Samuelsen and Steffen (2004, p. 5) explained that: "*Habitus* constitutes a practical logic rather than a conscious reasoning...*Habitus* is formed and forms the everyday practice of individuals" (further explored in section 2.5 below). Despite the limitations, health behaviour models are applied to a broad range of health behaviour strategies and can provide one way to view patterns of acting with regards to health that can be useful when wider factors are taken into account.

2.4. A Narrative 'Corpus of Stories'

One way to discover lay models of health is through a narrative approach (Harter et al., 2005), where participants make sense of health, giving their experiences meaning and signification, within the wider context of their life experiences. People explain being ill and the perceived causes of their illness through the narratives they construct, where the biographical and sociocultural intertwine (Charmaz, 2006; Dorazio-Migilore et al., 2005). Good (1994, p. 164-165) proposed that:

...much of what we know about illness we know through stories – stories told by the sick about their experiences, by family members, doctors, healers, and others in the society. This is a simple fact. "An illness" has a narrative structure, although it is not a closed text, and it is composed as a corpus of stories.

Garro and Mattingly (2001, p. 1) summarised that: "Narrative is a fundamental human way of giving meaning to experience. In both telling and interpreting experiences, narrative mediates between an inner world of thought-feeling and an outer world of observable actions and states of affairs."

Narrative enables people to explore answers to the question: Why did I get this illness? and to:

"...restore a view of the world as coherent, cohesive, and predictable..." (Shiloh et al., 2002). Helman (2007, p. 141) proposed that: "...understanding narratives is an intrinsic part of understanding the nature of human suffering and the many dimensions of illness". People use narrative to engage in sense-making, and through this process they work out their place in the world, and how to live meaningful lives (Harter et al., 2005).

This approach contrasts with the doctor initiated medical history which is constrained by a symptom-driven, linear, question and answer, biomedical format and there are opportunities to improve the health professional-patient encounter through the intersection of narrative and medicine (Charon, 2012; Hunter, 1993). Hunter (1993) proposed that it is a patient's job to tell the doctor what hurts, and the doctor's job is to fix it. But how does the doctor know what is wrong? What becomes of the patient's story when the patient becomes a case? Narrative is integral to the medical encounter, to communications by and about the patient, and to the structure and transmission of medical knowledge. For example, the patient's story is told to and interpreted by the physician, who then tells another story of the patient, in case format to other physicians, and records that story in a formulaic chart entry. Hunter (1993) observed that most of the rituals and traditions of medicine and medical training are narrative in structure, and explained why narratives such as cautionary tales, anecdotes, case reports and clinical-pathological conferences are central, not peripheral, to medicine. She proposed that if the narrative structure of medicine is fully recognized by physicians, they will attend to their patients better and acknowledge the details and importance of their patients' individual life stories.

Narratives derived through a process of sense-making differ to those elicited in the clinical encounter. Some clinicians have elaborated on the case history genre by expanding into illness stories that reflect on what the experience of disease can teach us about the nature of human suffering (Sacks, 1973, 1985, 1986). Other researchers have focused on documenting personal accounts of illness (DiGiacomo, 1987; Murphy, 1987). Brody (1987) has examined literary accounts of illness and argues for the inclusion of narrative dimensions of illness in matters of medical ethics. Mattingly (2006, p. 568) concurred, commenting that: "An interest in narrative within the clinical world has been linked to a concern with ethics – with how to provide a more humane, a more 'human-centred' approach to health care". Mishler (1986a, 1986b), who studied doctor-patient discourse, criticised survey interviewing practice in light of learnings from research into the narrative structure of conversation. Some cognitive anthropologists have found that cultural knowledge is encoded in illness narratives (Garro, 1992; Price, 1987).

Early's (1982, 1985, 1988) research on 'therapeutic narratives' was among the first by an anthropologist to focus on illness and care-seeking stories which, she argued, operated as a middle level system between experience and theory for the women she interviewed in Cairo. In her thesis, Mattingly (1989) used narrative theory to look at the story-experience relationship in the use of narratives by clinicians. Good (1994, p. 142) summarised that:

Much of the literature on illness narratives has addressed the structural characteristics of illness stories, their relation to life histories, the kinds of illness knowledge and values they encode, and what they reveal about the impact of illness on people's lives. In general, this "narrative turn" in writing on illness experience has benefited from broader interests in literary analysis in the humanities and social sciences...Anthropological analyses of narrative have been largely of two kinds: structuralist studies of folklore and mythology, and sociolinguistic studies of narrative performance.

Health and illness narratives are broader than the individual, and Good (1994, p. 158) warned that: "It would be a grave error to conceive illness narratives as the product of an individual subject, a story told by an individual simply to make sense of his or her life..." because suffering is positioned in the field of social relations, and illness is culturally shaped through narrative. In our attempts to make sense of our lives, narratives provide powerful shaping forces that: "...emerge as complex performances in the midst of enveloping life and social narratives that can enable or constrain, stigmatize or empower, confuse or enlighten individuals as they attempt to restore continuity when faced with the disruption of illness, suffering, or trauma (Harter et al., 2005, p. 29). Wikan (2000, p. 218) asserted that illness narratives are not only about "my illness and me", as often reflected in Western academic literature, but are, in her experience in the field and at home, more about the "on-going stories of their lives" reflecting social relationships and the complexity of everyday life. Wikan (2000, p. 230) commented that: "An illness story need not be about illness at all, or illness may be only a part, and not the most salient part, or what the teller (or narrator) seeks to convey". Saris (1995, p. 39) expanded this textualised view of narrative, by proposing that illness narratives are not simply stories of personal experience, but are: "...deeply embedded within various institutional structures that influence its production as a story". Illness narratives are more than a personal story of experience, they reflect wider life circumstances and experiences and how people make sense of these. Stories of health and illness do not exist to simply record facts, they are: "...shaped for narrative purposes with a view toward meaning and signification..." (Bruner & Feldman, 1996, p. 293).

Reflecting the understanding that disease occurs in the domain of life, not simply within the body, Good (1994, p. 133) proposed that: "...narratives are central to the understanding of the experience of illness...in relation to other events and experiences in life" and these illness narratives are structured in cultural terms, as revealed by lived experience. Good (1994, p. 121) asserted that "All narratives, as theorists from Aristotle to Kenneth Burke to Hayden White have shown, are stories about lived

experience. They describe events along with their meaning for persons who live in and through them”. While we do not have direct access to the experiences of others, Good (1994, p. 139) suggested that: “We can inquire directly and explicitly, but we often learn most about experience through stories people tell about things that have happened to them or around them” and that:

Narrative is a form in which experience is represented and recounted, in which events are presented as having a meaningful and coherent order, in which activities and events are described along with the experiences associated with them and the significance that lends them their sense for the persons involved. But experience always far exceeds its description or narrativisation.

Harter et al (2005, p. 7) asserted that: “An increasing number of scholars across disciplines envision narrative as a new frontier for advancing health-related theory, research and practice” and reference various authors including: rhetoricians, medical anthropologists, sociologists, physicians, psychologists, and communication scholars as examples of research where narrative facilitates emergent social selves, relational identities, and co-cultural understandings. Medical anthropologists have developed a number of concepts and models in an attempt to understand these culturally shaped narratives, including the explanatory models and the theories of illness causation described in sections 2.2 and 2.3 above. People explain the earlier causes of illness through narratives of the circumstances surrounding the illness event, as well as the illness event itself (Helman, 2007). These ‘stories of sickness’ relate illness to the wider cultural and social environment in which the illness is experienced, making sense of, and giving meaning to, the experience (Brody, 2003). The illness story is therefore culture-imbued and becomes what Becker (1997) referred to as ‘cultural documents’ in the life story of a person. The biomedical model, on the other hand, attempts to organise the illness story into a linear form which is marked out by chronological timelines and conceived of in terms of a medical ‘case history’ as opposed to the wider cultural and social concept of ‘life history’ (Brody, 2003; Helman, 2007; Kleinman, 1988). A review of one’s own personal health records would provide a good example of this linear approach. Harter et al (2005, p. xii) asserted that while: “Medicine prefers the restitution story that projects a future of the patient being restored to her condition prior to illness. Ill people learn to tell the quest story, in which illness is understood as a source of some insight that needs to be shared with others”.

Frank (1998) described three types of illness narrative: the restitution story, the chaos story and the quest story. The restitution story is optimistic and has a focus on taking action to conquer the disease enemy with the ‘weapon’ of biomedicine. Lupton (2003, p. 95) commented that the restitution story is

“...culturally preferred” in Western societies, but that for those whose illness narratives cannot include recovery (i.e., terminal or chronic conditions) they may be marginalised by the cultural dominance of the restitution story. In contrast, the chaos story has a pessimistic take on the illness experience where the person has no control over the illness which is systematically destroying aspects of their life. Finally, the quest story represents the illness experience as a journey from which something can be learned. Although optimistic like the restitution story, this narrative can accommodate illnesses that do not include recovery by focussing on the ways in which the experience has changed peoples’ lives for the better. For example, a person with a terminal illness might say it has resulted in them appreciating and living each day to the full, in a way they had not before the illness (Frank, 1998).

The purpose of illness narrative can be viewed in a number of ways. Buchbinder (2010, p. 110), referencing various studies, summarised that: “...illness narratives are rhetorical accounts that may be designed to elicit a particular interpretation of the condition, restore the moral position of the teller, or provide a means to some other end”. Within these stories, disease is sometimes referred to in impersonal terms like ‘it’ or ‘the disease’, indicating that the disease is viewed as a separate ‘thing’ from the person. This ‘thing’ is often described in language which indicates the disease is an unwanted invading object which must be removed in order to restore bodily integrity. There can also be a moral aspect ascribed to the illness narrative, with individuals questioning whether something they did resulted in the illness. For example, a person may feel that their history of eating and drinking too much alcohol resulted in a heart attack, which they deserved because of the life choices they made. Personal and societal blame for illness (the pejorative nature of ‘healthism’ as discussed in 2.2 above) is well demonstrated by the moral explanations ascribed to the contraction of HIV/Aids as either ‘innocently’ through a blood transfusion, or contracted by a person’s ‘own fault’ through homosexual or promiscuous activity. Continuing genetic advances also shape illness narrative as science shapes the public debate from personal responsibility to the susceptibility of some to genetically attributable diseases (Lupton, 2003).

Through narrative, people attempt to make sense of their lives in time through an interpretive framework; they remember how and why things have happened in the past, they link that remembered past to their present, and they explore how this might shape their future. In this way, narrative allows people to describe their lives in time; “...a life is not ‘how it was’ but how it is interpreted and reinterpreted, told and retold (Bruner, 1987, p 31). Hallowell (1955, p. 94) noted that: “Human beings maintain awareness of self-continuity and personal identity in time through the recall of past

experiences that are identified with the self-image” (see also Wang and Conway (2004)). A number of researchers develop the time aspect to narrative by drawing on Martin Heidegger’s phenomenological concept of temporality, where our lived experience in time is situated between a past and a future, and we are constantly engaged in a process of ‘becoming’ by organising the past and anticipating future possibilities through narrative (Mattingly, 1998; Ochs & Capps, 2001).

Linking narrative and habitus is a theoretical possibility and useful for this study, where participants make sense of health within the wider context of life experiences that become embodied over time. Referencing a number of studies linking narrative to habitus, Smith (2007, p. 395) summarised that: “...a life narrative can be considered a construction that is resourced by past constructions that may aggregate over time”, resulting in continuity in the stories people tell which produces a sense of consistency in their identity. This possibly durable and transposable dimension of narrative can be integrated and regenerated through the body across time and in space, and therefore become an ‘embodied narrative habitus’ (Smith, 2007). However, people can and do change, and their stories can and do change:

They are predisposed to act in predictable ways, but predispositions are constantly being modified. Accordingly, the concept of embodied narrative habitus may offer insights into how and why an individual’s self-narrative changes, as well as resists this process (Smith, 2007, p. 395).

Frank (2010) extended the literary study of narrative by including the storied quality of everyday life. He proposed that stories have the capacity to act, and that stories evolve alongside people; both shape each other. This evolution and shaping occurs between tellers and listeners and demonstrates the embodied nature of stories, resulting in a kind of ‘narrative habitus’ as stories shape lives. Habitus and narrative allows for an exploration of the relationship between the content of the stories we tell, and their potential consequences on our dispositions to think, feel and act. Miles (2011, p. 402) summarised that:

Frank argues that stories call upon their characters to become particular selves and call upon listeners to see themselves in particular characters. Responding to this call, over time, results in narrative habitus. Narrative habitus demonstrates that our ability to draw on narrative resources is often tied to social location. The stories that we come to embody and the dispositions that we

hold allow us to draw on a repertoire of stories, display competence in telling and responding to stories, and lead us to predict how stories will end.

Ricoeur (1981) referred to the sequential and unfolding nature of narrative as 'narrative time' and Turner (1957, 1981) argued that a structure lies beneath narrative that moves inexorably from a breach of an existing state, to a crisis, and finally to redress. Good (1994, p. 145) suggested that: "Predicament, human striving, and an unfolding in time toward a conclusion are thus central to the syntax of human stories, and all of these...are important to stories about illness experience". Garro (2003, p. 40) referred to the breach of an existing state as 'trouble', and characterised the concept of 'trouble' as the "engine of narrative". Bruner (1996, p. 99) asserted that: "It is the whiff of trouble that leads us to search out the relevant or responsible constituents in the narrative, in order to convert the raw Trouble into a manageable Problem that can be handled with procedural muscle". In this way, narrative provides an orderly structure in which to construe reality, linking current 'trouble' with perceived pasts and/or possible futures (Garro, 2003). As discussed in Section 2.2 above, heuristics can inform lay models of health. This study found that the participants lay models of health were informed by their previous experience of an illness event, as well as their access to the experiences of others, and mass media portrayal of illness/health (Chapter Seven). These were often revealed through stories which had a more powerful impact on their explanatory models than scientific knowledge, and therefore narrative could be thought of as heuristic in that way (i.e., a story of an illness event illustrating how one thing leads to another, with the underlying understanding that the causal association is replicable in similar circumstances).

Good (1994, p. 143) expanded on the temporal and procedural constructs by proposing that: "Reading response theorists have elaborated on the temporal and intersubjective qualities of narrative". Narrative is not simply 'narrative time' or a structured story alone, it must be received by a reader or listener in order to be truly created. Iser (1978, p. 21) explained that: "...the reader 'receives' [the message of the text] by composing it" and that: "...the interpreter's task should be to elucidate the potential meanings of a text" (1978, p. 22-23). This process of meaning-production reflects a dynamic interaction between the reader and the text. Harter et al (2005, p. xv) and others describe this aspect of narrative as co-construction, where: "Narrative inquiry always takes on a multi-layered, nested quality including stories told, co-constructed, and eventually narrated in research texts". Good (1994, p. 144) contended that reader response theory has relevance in the discussion of illness narratives, arguing that researchers are seldom told a story in sequence and that stories change as key events unfold. Stories also point to

the future with hope and anxiety, and are deeply cultural. Stories are told in order to make sense of the experience, and the past and present are often reworked through the telling process.

Two theoretical aspects of plot are important for health and illness narratives. Firstly, plot in the traditional literary sense which provides meaningful order, often sequential, between experiences and events, turning fragments of narrative into a story (Good, 1994). Brooks (1984, p. xi) described plot as:

...the design and intention of narrative, what shapes a story and gives it a certain direction or intent of meaning. We might think of plot as the logic or perhaps the syntax of a certain kind of discourse, one that develops its propositions only through temporal sequence and progression.

Secondly, 'emplotment', which is the imaginative and creative activity where the reader or hearer of the narrative engages in making sense of the story. Good (1994, p. 164-165) proposed that:

...illness stories, once told, break free of their original discursive or performative setting. They are "entextualised," in Ricoeur's (1981, p. 197-221) sense of the word. They are told and retold, made available to multiple "readers". Their effects and interpretations are unpredictable; they cannot be controlled by the author, by the teller of the tale...the sufferer is not only a narrator of stories but is, in several important senses, similar to a "reader". Those with an illness find themselves in the midst of "reading" a story, often helpless to affect its outcome, constantly revising interpretations, judgements, hopes, and expectations as the narrative time progresses.

Engaging in 'emplotment' provides subjunctivising elements to narrative. Bruner (1986, p. 26) proposed that narrative succeeds by "subjunctivising reality" and that: "To be in the subjunctive mode is...to be trafficking in human possibilities rather than in settled certainties". Good's (1994, p. 153) view supports this assertion with his argument that:

Illness stories contain subjunctivising elements not merely because they are narrative in structure and are performed to elicit an imaginative and empathetic response from an audience. They also have such subjunctivising elements because the narrators – the person with an illness, family members participating in their care, medical professionals – are in the midst of the story they are telling...The analogy of the reader in the midst of a story, drawn almost against his or her will into the world of the text and moving forward, reinterpreting the past in light of the emergent present and future...

Health and illness narratives allow for the exploration of the mysterious, the ‘irrational’, and therefore the potential for change. Mattingly (1998) found in her study that patients and therapists can even achieve ‘therapeutic employment’ through the creation of positive narrative form from the illness narrative. Narratives are creative and have the potential to ‘recast reality’ in response to the mysterious (Good, 1994). Good referred to this maintenance of alternative perspectives and the representation of the mysterious as two “subjunctivising” elements in illness narratives and suggested that:

The stories have “gaps”, the unspoken or unexplained, that represent unknown or unknowable dimensions of reality that offer hope that potent, untapped sources of efficacy will yet be found. The quest structure of the narratives...presupposes subjunctivity. The openness of time horizons – the representation of the future as a potent source for change and healing – is a central subjunctivising theme in many of the stories (1994, p. 157).

This subjunctivising dimension of narrative provides for a ‘network’ of health and illness perspectives which provide insight into the nature of the illness experience as an experience that is: “...grounded in human historicity, in the temporality of individuals and families and communities” (Good, 1994, p. 157). In order to produce narrative, individuals must have access to this network of cultural resources which provide: “...culturally available understandings (or cultural knowledge) about illness and misfortune” (Garro, 2003, p. 6). Qureshi (2010, p. 277), however, provides cautionary advice to those engaged in the subjunctivising dimension in his study of the sickness, dreams and moral selfhood among migrant Pakistani Muslims, finding that: “...the notion of the ‘subjunctive mode’ imposes the analysts’ own system of logic and that there is a need to understand the interpretive frameworks present in the illness narratives in their own terms”.

This research takes a narrative approach in the study design (see Chapter Three), as a theoretical approach as described in this section, and in the overall narrative form of the thesis which builds a ‘portrait of a people’ chapter by chapter.

2.5. The Generative Nature of Habitus

This research explores participants’ conceptions of health and health keeping practices through narrative sense-making, which is positioned within the wider context of their life experiences. Bourdieu’s (1990b, 1999) theory of habitus provides what may be described as ‘post-cultural’ (Lizardo,

2011) theoretical tools such as habitus, field, and capital, which mediate between structure and agency (Davey, 2009) and are useful to a multigenerational study of community health in a migrant context as they allow for an exploration of the structures of social being, the foundations of knowledge, and the hidden possibilities of history (Wacquant, 2006, pp. 261-277). Habitus includes both durable qualities and the “permanent capacity for invention” (Bourdieu, 2004, p. 63) allowing the potential for change and adaptation. Brown, Crawford, Nerlick & Koteyko (2008) propose that Bourdieu is particularly pertinent for understanding work in healthcare (Bourdieu, 1990b, 1999; Bourdieu & Wacquant, 1992; Fowler, 1997), even though some of his ideas have been received critically¹⁴ (Mouzelis, 1995, pp 100-116; Sallaz & Zavisca, 2007; Sayer, 1999; Verdaasdonk, 2003).

My interest in Bourdieu emerged from my theoretical journey starting with reading Max Weber, Edmund Husserl (with a brief consideration of phenomenology), Marx, Claude Levi-Strauss (on which Bourdieu’s theories were built) as well as Heidegger, Foucault and others. I had also canvassed phenomenology and structuralism, but what appealed with Bourdieu was his attempt at reconciliation between these through habitus and field. Bourdieu’s somewhat controversial attempt at reconciling structure and agency (external social structures and subjective experience) found a fit with the key elements of my study in the design stage and supported my plan to use anthropological approaches in a community health study. Other theorists / philosophers did not provide such a span of opportunity to investigate the circumstances people find themselves in (and create), their bodies, as well as what they think, as well as what they do. Bourdieu’s theories were useful because they allowed for an exploration of the intersection between meaning and structure (a key premise of this study being that “Human health can be understood, in part, as the intersection of meaning and structure” (Dressler, 2007, p. 30)), and also supported a reflexive approach, which was important for a study where I was a member of the participant group.

Central to Bourdieu’s theoretical work is the notion of habitus which is defined as: “...the durable and transposable systems of schemata of perception, appreciation, and action that result from the institution of the social in the body” (Bourdieu & Wacquant, 1992, p. 126). Habitus can be described as a ‘conductorless orchestration’ that gives systematicity, coherence, and consistency to a person’s practices (Bourdieu, 1990b, p. 59). Social practices are structured by habitus, and people develop a

¹⁴ Bourdieu has been criticized in various ways including for: overestimating similarities between people, attempting to introduce a new structuralism (Stam, 2009, p. 707-708), being too static and too specific to French society (Sallaz & Zavisca, 2007, p. 25), for doing away with the agency of the conscious human subject (Throop & Murphy, 2002, p. 198), and for being overly deterministic (Davey, 2009). Another common criticism of habitus is that it is static and cannot account for change, however, habitus is in fact generative, rather than determinative (Bourdieu, 2004).

‘taste’ for what is available to them. Habitus is the idea that social groups acquire collectively held common-sense patterns of thinking and acting, which are often taken for granted by the group (Rhynas, 2005, p. 185). These patterns of thinking and acting, which are influenced by histories and ‘sedimented’ by past and present experiences, may be expressed through choices, traditions, manners and practical ways of doing things. By its very nature, habitus is transferrable across generations through the sedimentation of everyday patterns and practices. These patterns are also influenced by: “...the public meta-narratives regarding what constitutes appropriate, gendered behaviour(s) or expressions of belief” (Robertson, 2006, p. 178). Habitus is composed of practical logic, rather than conscious reasoning, and is formed, and forms, the everyday practice of individuals (Samuelsen & Steffen, 2004). Bourdieu described habitus as history transformed into nature, and proposed that what we sometimes think of as being innate, natural or endogenous processes are actually: “...never anything more than the forgetting of history which history itself produces by incorporating the objective structures it produces in the second nature of habitus (Bourdieu, 1977, pp. 78-79). Ahmed and Jones (2008, p. 60) described this as: “...the way the social is internalised individually; integrating all past experiences in the form of durable, lasting and transposable dispositions to think, feel and act”. The influence of habitus is not simply unidirectional however: “...as individuals resort to their habitus to structure their perceptions and actions, habitus in turn enables the reproduction of the very same social structures that produce them in the first place” (Lo & Stacey, 2008, p. 745).

While people are free to make choices, those choices are somewhat limited and influenced by their habitus and their resources, or capital, according to Bourdieu. However, while individual behaviour, values and thoughts are organised and shaped through habitus (Lee & Macdonald, 2009), habitus is not deterministic; it is rather a generative principle, or a structuring disposition to think and act (Bourdieu, 1990b, p. 52-53; Hilgers, 2009). Brown, Crawford, Nerlick & Koteyko (2008, p. 1048) propose:

The biographical and historical trajectory of an individual will predispose them to specific ways of perceiving, conceiving, reasoning and acting. This shapes tastes, desires and systems of morality in a manner which often escapes conscious attention.

Dispositions that incline people to think and act in certain ways are shaped by experiences, particularly childhood experiences, through a process of inculcation, and through this process habitus becomes embodied. Sallaz and Zavisca (2007, p. 25) proposed habitus is: “...less a set of conscious strategies and preferences than an embodied sense of the world and one’s place in it – a tacit “feel for the game” (Bourdieu, 1984, p. 114; Bourdieu & Wacquant, 1992, pp. 128-135). Carlson and Hall (2011, p. 191) summarised that:

Dispositions are structured in accordance with the social conditions and language of the time in which they are created. Structural dispositions have a lasting quality that is ingrained in the body and maintained through life. As a durably installed set of dispositions, the habitus produces behaviours and perceptions that reflect the social conditions and language of the time they were created. These behaviours and perceptions appear natural and thus are not examined critically by those who are acting; nor are they examined by observers of the behaviour.

However, habitus is not static and dispositions can be changed, for example, in response to migration experiences (Wacquant, 2004). This has particular relevance to this study, where the participants born in Finland may have brought with them dispositions and practices based on their lives in Finland, and these in turn may have changed in response to the circumstances they found themselves in, and also constructed, in New Zealand.

Bourdieu (1992, p. 126) argued that habitus is inherently social: "...to speak of habitus is to assert that the individual, and even the personal, the subjective, is social, collective. Habitus is a socialised subjectivity." Habitus is therefore:

...a matter of socialisation and the adaptation of the individual's ambitions and actions to the social circumstances in which they live. But habitus is also a matter of the way in which people react to, and actively handle, their social circumstances (Korp, 2008, p. 19).

Within this socialised subjectivity, the practices of everyday life form the habitus:

There is every reason to think that the factors which are most influential in the formation of the habitus are transmitted without passing through language and consciousness, but through suggestions inscribed in the most apparently insignificant aspects of the things, practices of everyday life (Bourdieu, 1991, p. 50).

The social practice of habitus develops from a person's structural position in the field, according to Bourdieu. Society is made up of many fields, each of which have their own logic and dynamics, and can be distinguished by particular structures, institutions, authorities and activities (Bourdieu, 1999; Bourdieu & Wacquant, 1992; Rhynas, 2005). Fields designate a specific space of social relations and therefore fields can be constructed in many different ways for analysis i.e., the field of health, the field of migration, the multigenerational field. In each field a different type of social game is being played, and players acquire a feel for the game. These social games have different rules of engagement, which

require different resources and competencies from players, and a number of different outcomes can result (Brown et al., 2008, p. 1048). Like any game, a field has rules, stakes (capital), and strategies for playing; through the process of playing, players become invested in, and absorbed by, the game (Bourdieu & Wacquant, 1992, pp. 98-100).

Habitus is enabled by various capitals, however, not every player has access to the same resources required for the social games that are played out in the field. For example, in the field of health, not all people have access the same health resources in their quest for a healthy life; not all people are part of a supportive social network. Capital, or resources that provide different forms of power, takes three basic forms according to Bourdieu: economic capital which are economic assets such as money and accumulated productive assets; cultural capital which is competence and knowledge of the conceptual and normative codes of a specific culture; and social capital which are social resources linked to a social network which can mobilise power and resources (Bourdieu, 1986, p. 119; Bourdieu & Wacquant, 1992). These three types of capital can become symbolic capital when it is: “...misrecognised in its arbitrary truth as capital and recognised as legitimate” (Bourdieu, 1990a, p. 112) and therefore gains specific symbolic efficacy. Meinert (2004, p. 12) argued that:

...in relation to health the body is not merely the carrier of habitus, as implied by Bourdieu (2000). Instead, I suggest that the body is also a form of capital, which might be added to Bourdieu’s theory of forms of capital. Human beings are embodied differently from birth, and as other scholars have pointed out the body is worked upon like other forms of capital (Shilling, 1993; Wacquant, 1995)”.

2.6. The Culturally Constructed Experience of Health

The research participants drew extensively on their cultural cache as they constructed, applied, and transferred their lay models of health across generations (explored in Chapters Five to Eight), and the concepts of culture and health were found to be closely linked in the literature. Hruschka and Hadley (2008, p. 947) proposed that culture affects health in three main ways: through the application of culturally specific explanatory models to health-seeking and prevention practices; through the protective nature of some cultural habits and practices; and “...culture indirectly influences health when learned beliefs, values, and norms, affect such daily activities as food consumption, physical activity, and drug use in a way that increases (or decreases) the risk of non-communicable diseases”. Cultural constructs influence how people, and their health professionals, think about health issues and

treatments. Culture influences patterns of thinking and acting, and in this way can influence exposure to disease as well as experiences with health care, including: whether or not people would seek care, how they would describe their health issues, and whether or not they would comply with treatment (Bannerman, Burton, & Wen-Chieh, 1983).

A number of studies found that aspects of culture have the potential to significantly affect perceptions of health as well as health behaviour, such as actions taken to prevent illness and actions taken once one is ill (Guo & Phillips, 2006; Leininger, 1991; Sobralske, 2006; Stone, 1992; Torsch & Ma, 2000). Winkelman (2009, p. 18) asserted that: "...health concerns can be best understood in relationship to culture. Biomedical views of health based strictly on biology impair understanding of underlying causes of disease that result from social conditions". According to Gregg and Saha (2006b, p. 545): "...culture matters in health and health care. It affects every aspect of our lives – what we eat, how we work, how we play, and how we think about disease, health, and healing. Manderson (1990, p. xiii) proposed that: "People's attitudes towards health promotive behaviour, their ability to recognise signs of illness, and their understanding of disease are all culturally determined" and that:

Social scientists have shown that health and illness are culturally constructed experiences, and that these experiences vary according to social context. While disease has a biological cause, responses to disease, and understandings and ideas about sickness and health are social phenomena, as are the interpersonal relationships, social structures and organisations that influence people's experience of sickness (1990, p. xi).

In his seminal series of articles on culture, Geertz (1973) proposed that cultural systems can both express the nature of the world and shape the world to their dimensions, thereby achieving a sense of reality that is essentially a by-product of symbolic forms. The argument is that cultural systems must be investigated and understood given their capacity to shape perceptions. Kleinman (1975) gave further weight to the relevance of culture to health, proposing that culturally constructed conceptions of health result in an extensive array of unique patterns in health-seeking and maintenance behaviours in different societies, concluding that illness and health care are directly woven into the cultural fabric of life. Socio-cultural theories posit that beliefs, values and cultural practices are determinants of diseases by virtue of their symbolic influences on biological processes (Winkelman, 2009). The ability, therefore, to resist disease comes from the impact of cultural mores and practices on health behaviours and physiological responses such as health and stress responses. Winkelman (2009, p. xvii) proposed that: "...health conditions are generally not directly caused by biology – genetics, viruses, or bacteria –

but, rather, by the effects of individual and collective cultural behaviours such as diet and resources allocation” and that: “...human health and disease derive from the interaction of human’s biological potentials with numerous environments through culturally, socially, and individually mediated experiences that have effects on biological processes”.

Some have proposed that biomedicine may fail if it does not take account of cultural and social issues (Groth-Marnat, Leslie, & Renneker, 1996; Stone, 1992), however, Good (1994, p. 2) cautioned that conceiving disease within a cultural domain is counter-intuitive and that: “...It takes a strong act of consciousness to denaturalise disease and contemplate it as a culture domain”. Surood and Lai (2010, p. 176) proposed that:

Culture is more than membership in an ethno-cultural group, it is a shared way of life and worldview passed down from previous generations. Culture affects health perceptions and behaviours based on the values and beliefs of an individual. Culture is not static and it evolves with time and circumstance. Studies indicate that the treatment of illness is more effective when it is culturally acceptable and recognised. Culture serves to assign meanings to the causes and symptoms of illness, and determines the type of treatment received.

While culture does matter in health, like conceptions of health, it does not necessarily cause behaviour:

...even if one does have some knowledge of another person’s cultural beliefs, this does not mean that it is possible to predict that person’s behaviour or preferences at any given time. Cultural beliefs do not simply “cause” us to behave in a certain way...Rather, as Ann Swidler has explained, individuals may use culture as a “toolkit” [or a repertoire] of symbols, stories, rituals, and world-views, which people may use in varying configurations to solve different kinds of problems (Gregg & Saha, 2006b, p. 544).

Helman (2007, p. 2), referencing Hall’s (1984) work, suggested that culture can be described as having three levels. The tertiary level is described by Hall (1984) as the “façade presented to the world at large” that is visible to outsiders through explicit manifestations such as: social rituals, traditional dress, food, and festivals. This level is the easiest to observe and change. The secondary level is comprised of a ‘cultural grammar’ of implicit assumptions, beliefs and rules that underpin the façade. This is a private world, rarely shared with outsiders. At an even deeper and primary level is an aspect of culture in which the rules are known to all, obeyed by all, but seldom if ever stated. Its rules are implicit, taken for granted, almost impossible for the average person to state as a system, and generally out of

awareness. This is the truly private world, rarely even shared with insiders, and the secondary and primary levels are the most hidden, stable and resistant to change. Described another way, there are three levels of cultural behaviour - what people say they do (i.e., what participants told me in their interviews), what they are observed doing, and the underlying belief system that drives behaviour. In addition, there is the wider socio-cultural / economic context in which the behaviour takes place (Greenhalgh, Helman, & Chowdhury, 1998). People do not just know or believe and think things, they *do* things as well (Bourdieu, 1988), and because there can be a difference between what people think, say and do, it is important to understand the influences on what people do. The things they do can be guided by a shared understanding of the world and the way in works which can be somewhat revealed by a cultural model. Individuals will experience varying levels of success in enacting their cultural model for a number of reasons, including the existence of structural barriers. Difficulty in enacting a cultural model can lead to poor cultural consonance, which can impact health outcomes (Dressler, 2007).

A number of studies have found that cultural factors shape, and are shaped by, individual health concepts and that culture has salience in health research, practice, provision and communication (Bina, 2008; Bryant, 2003; Guo & Phillips, 2006; Kandula, Lauderdale, & Baker, 2007; Karasz, Dempsey, & Fallek, 2007; Kreuter & McClure, 2004; McMullin, de Alba, Chavez, & Hubbell, 2005; Napoles-Springer, Santoyo, Houston, Perez-Stable, & Stewart, 2005; Papadopoulos, 1999; Rogers, 2010; S. Smith & Tessaro, 2005; Sullivan, Hicks, Salazar, & Robinson, 2010; Vahabi, 2010). For example, in their study of older African Americans and whites, Silverman, Smola and Musa (2000, p. 139) suggested that the concept of: "... 'healthy' may be a multidimensional construct more connected to ones' total life experiences than is 'not healthy'" and they concluded that: "...social and cultural factors such as race, ethnicity or health experiences may influence how individuals perceive and describe their health status and the processes used in making these assessments".

Migrant status as a cultural factor has also been found to influence aspects of health and illness (Abdulrahim & Ajrouch, 2010; Manderson, 1990). For example, in their study of the mental health perceptions, practices, and knowledge of Chinese American immigrant women, Tabora and Flaskerud (1996) found that culture was important in determining the pathway to care. A cross-cultural study of health perceptions, concerns, and coping strategies among Asian and Pacific Islander American elders by Torsch and Ma (2000) found that conceptions of health were closely connected to underlying culture and belief systems i.e., the principle of yin-yang balance for the Chinese participants, and that the key

to health and well-being is to be found by attaining a balance and harmony within one's culture. In her study of elderly Chinese Canadians, Meng (2008) found that cultural values played a major role in the Chinese elderly participants' dietary practices, and that these understandings resulted from their lived experiences, traditional culture, and personal preferences (including some childhood dietary preferences). Hoeman, Ku and Ohl (1996) investigated how cultural understandings may influence participation in early detection programmes for breast cancer in Chinese women who live in the United States of America. They found that understandings about susceptibility to cancer were congruent with their country of origin rather than with their country of residence, and that cultural understandings about modesty, husband's involvement, self-care, relationship between health and body functions, and use of preventative health behaviours in the absence of illness influenced women's participation in early detection programmes. A number of researchers have argued for the importance of culture in the health of Pacific Peoples and its relevance for public health policy in New Zealand (Ma'ia'i, 1994; Tamasese et al., 2005). Others have found that awareness and sensitivity to cultural factors are essential for the success of health interventions in the Pacific (Agnew et al., 2004; Braun, 2004; Davidson-Rada, 1999; Fong, Braun, & Tsark, 2003; Groth-Marnat et al., 1996; Puaina, Aga, Pouesi, & Hubbell, 2008; Ropiha, 1993).

The notion of culture has many similarities with Bourdieu's (1990b) theory of habitus discussed in 2.5 above. Like habitus, culture can be embodied, transmitted across generations, patterned, and should be viewed within the wider social and economic context. For example, Harvey (2008, p. 60) provided a broad and historical amalgam of definitions of culture, illustrating its embodied nature over generations:

Culture is "learned behaviour...not given at birth" (Benedict, 1943), formed of a "complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits by...a member of society" (Tylor, 1871). These practices, capabilities, habits, traditions, etc. "suspend [humankind] in webs of significance that [humankind itself] has spun" (Geertz, 1973), and to "begin with the personal" culture's continuation is "not so much a matter of preservation, as it is a matter of re-creation, by successive persons and generations, and in individual performances" (Hymes, 1975).

Helman's (2007, p. 2) contemporary description also reflected the embodied nature of culture as:

...a set of guidelines (both explicit and implicit) that individuals inherit as members of a particular society, and that tell them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the

natural environment. It also provides them with a way of transmitting these guidelines to the next generation – by the use of symbols, language, art and ritual. To some extent, culture can be seen as an inherited ‘lens’ through which the individual perceives and understands the world that he inhabits and learns how to live within it. Growing up within any society is a form of enculturation, whereby the individual slowly acquires the cultural ‘lens’ of that society.

Culture is ‘built up’ over lifetimes and transmitted generation to generation. Because it is ‘built up’ it is also dynamic, changing, flexible and adaptable, however, it is not arbitrary – culture is patterned. It involves: “...ritual actions, shared understandings and expectations. Cultural rules govern the most ordinary actions, including those actions which we take for granted and that affect our health: how we eat, eliminate, rest, and recreate, for example. We are all of and within culture” (Manderson, 1990, p. xiii). Culture changes through interaction with people of other cultures and these changes are reflected in our patterns, and changes in our patterns are reflected in our response to health and illness (Manderson, 1990). Referencing the work of both Geertz (1973) and Bourdieu (1990b), Joseph et al (2009, p. 77S) describe culture as: “...the patterned process of people making sense of their world and the conscious and unconscious assumptions, expectations, and practices they call on to do so” indicating that despite variation, culture is not random, there are consistencies that are simultaneously flexible and situationally responsive.

A number of researchers found that culture should always be viewed within a wider context and that it is almost impossible to separate cultural beliefs and behaviour from the wider social and economic context (Greenhalgh et al., 1998; Manderson, 1990; McMullin et al., 2005; Papadopoulos, 1999). Learning about culture is not a panacea for health disparities and Gregg and Saha (2006b, p. 544) cautioned that: “...a focus on culture may dangerously distract us from disturbing issues of racial discrimination in health and health care” and that: “...as long as the poor and socially disenfranchised do not have access to affordable, quality, health care, attempting to bridge cultural distance is not the only, and probably not the most important, step clinicians and policymakers can take to alleviate health disparities” (2006b, p. 545). This is supported from a nursing perspective by Drevdahl, Canales and Dorcy (2008, p. 14) who agreed that while individuals most likely benefit from care that acknowledges cultural differences: “...healthcare disparities exist at a population level, and therefore require broader theoretical acknowledgement of structural processes and practices of power”. We also need to be critical about the links between culture, race, and ethnicity according to Gregg and Saha (2006b, p. 545) who advised that: “Just as learning about culture will not eliminate disparities, neither will it

eliminate racism...members of a particular racial and ethnic group do not necessarily share the same cultural background or beliefs”. However, sensitivity is not enough in the face of gross socio-economic disadvantage. In his study on the effects of tuberculosis in Haiti, Farmer (2006) found that health beliefs had no effect on whether or not people sought treatment for tuberculosis (TB), rather, once resources were made available to enable access treatment was taken up. Farmer exhorts social science researchers to not engage in ‘immodest claims of causality’ and instead look wider than a simple causal link between beliefs/culture and health outcomes such as TB, taking into account economic and other barriers to effective care.

The wider context of culture and health is apparent in the emergence of ‘culturally competent’ care which aims, in part, to reduce racial and ethnic disparities in health. Lo and Stacey (2008) developed a conceptual model for understanding the role of culture in the clinical encounter (drawing on Bourdieu’s (1990b) theory of habitus), paying particular attention to the relationship between culture, contexts and social structures and theorised that patients develop collective orientations towards their health:

Habitus thus theorises a type of cultural mechanism embodied in social agents yet functioning below consciousness, structured yet improvisatory, generative but context-bound...The emphasis on habitus functioning largely below consciousness while embodied in individuals broadens our view of patient culture from a set of beliefs or values to larger cultural orientations that shape decision-making and social interaction... (Lo & Stacey, 2008, p. 745)

The idea that culture is singly causal or determinate has largely been superseded by the understanding that culture is infinitely more complex and only one part of an intricate web of influencing factors and that it is: “...often difficult to disentangle cultural and ecological explanations, as ecological conditions such as neighbourhood activities, city layout, or social hierarchy are themselves shaped by local norms, values and behaviours” (Hruschka & Hadley, 2008, p. 947). Dorazio-Migliore et al (2005, p. 341) proposed that culture: “...involves explication of broader social, cultural, historical and geographical contexts, and a critical examination of the nature and location of culture” and that to ignore the dynamic nature of culture is to: “...view people as lacking the agency to bring about change. It leads us to treat people of particular backgrounds as simply carriers of some ‘traditional’, timeless and unexamined culture”.

Culture is different to ethnicity or race, and is a process that changes over time and space. Culture, therefore, is: "...the outcome of a group of people and their diverse, often overlapping, sometimes contradictory, creative attempts to make sense of their world and live in it" (2009, p. 77S). The tendency to over-simplify or stereotype based on 'culture' should be avoided as culture is complex, mutable, problematic and frequently contested; therefore peoples' lives will not fit into a nice neat cultural 'box' (Gregg & Saha, 2006a) (see also (Dorazio-Migilore et al., 2005; Kao, Hsu, & Clark, 2004; Mohammed, 2006)). Adding to this complexity, individuals may identify with more than one culture (the multiple cultures in play for a man who is a migrant doctor with cancer for example) and therefore people may hold: "mutually contradictory or mutually reinforcing values that the individual somehow must negotiate" (Gregg & Saha, 2006b, p. 544). In their extensive literature review on providing culturally appropriate care, Williamson and Harrison (2010, p. 761) found that:

Most of the literature focuses on the cognitive aspects of culture and recommends learning about the culture of specific groups which is presumed to apply to everyone. This generic approach can lead to stereotyping and a failure to identify the needs of the individual receiving care.

Any tendency to over-simplify would have implications for policy-making as: "...policy-makers may design policies underpinned by cartoon-like generalities, rather than those incorporating the nuances of salient differences and similarities among people. There is a strong need, therefore, to have complex, dynamic views of culture that avoid some of these problems" (Dorazio-Migilore et al., 2005, p. 341). Culture is a highly dynamic and complex term and the way in which it is conceptualised and used has significant consequences for health care (Dorazio-Migilore et al., 2005). Williamson and Harrison (2010) cautioned that a generic approach to culture can lead to stereotyping and a failure to identify the needs of the individual receiving care, and Gregg and Saha (2006b, p. 545-546) warned that:

...culture is mutable and multiple. Therefore, any understanding of a particular cultural context is always incompletely true, always somewhat out of date and partial. That said, the logical conclusion is not to throw up one's hands and walk away from the whole endeavour...instead to recognise the limitations of cultural analysis and know that while it is not possible (or even desirable) to codify abstract realities, it is possible to recognise and attend to those realities, and in the process to learn something, if not everything, about particular cultures and their impact on health.

Lo and Stacey (2008, p. 741) summarised the practical policy issues associated with the concepts of culture and health:

On the one hand, culture becomes an overly deterministic force that awkwardly lumps members of a given racial and ethnic group together, irrespective of social context and variations within the group. On the other extreme, culture is viewed as largely idiosyncratic and subjective, making standardised cultural competency guidelines nearly impossible to implement.

Variations of Leininger's definition is commonly referenced in transcultural nursing literature, describing culture as: "...the learned and transmitted values, beliefs, and practices that provided a critical means to establish culture care patterns from the people" (2002, p. 9). Dorazio-Migliore et al (2005, p. 342) described this definition as a: "...perspective in which the ingredients of each unique 'culture' are viewed as readily identifiable" and Mohammed (2006, p 98) commented that: "Recent nursing scholarship has moved away from essentialising notions of culture and identity toward understanding these as more fluid and complex, historically situated, and discursively constructed".

2.7. Summary

The review of literature found that the field of community health (within the interest area of what people think, feel and do about health) was not particularly well bounded from a theoretical perspective. This chapter developed a theoretical base for the research to allow for a multigenerational exploration of community health within a migrant/multicultural context. The theoretical base includes: conceptual elements, lay models that give shape to those conceptual elements and can influence behaviour, narrative as a mechanism to give meaning to the experience of health, the idea of habitus as a structuring (but not deterministic) disposition to think and act, and literature that reveals health as a culturally constructed experience.

The exploration of the Bourdieusian (1990b) 'field of health' found that health is a complex, dynamic, and multidimensional concept. How people understand this complexity can be revealed by their lay model of health which can be useful if the multidimensional and embedded nature of health is taken into account. While there may be similarities across groups, a lay model of health is unique to the individual and may differ considerably to the 'medical gaze' of their health professional, and this may affect quality of care. Despite their limitations, lay models can influence health behaviour, particularly when wider factors are taken into account. However, what people understand about health, or say they

understand about health, does not always equate to health behaviour; factors such as gender, values, the environment, access to resources, and embodied social experiences must also be taken into account.

This research discovered lay models of health through narrative, where participants were able to make sense of their experience of health, giving it meaning and signification, within the wider context of their life experiences. These wider influencing factors (such as migration, policy, generational experiences and living in Kawerau) were further explored through the generative, yet context-bound, principle of habitus (Bourdieu, 1990b) which provided an embodied and generational view of how participants think, feel and act in the field of health, drawing on their unique migrant and multicultural history. The resultant conceptualisations also illustrated the difference between the largely policy and biomedically constructed notions of health as Western or Non-Western and the more multidimensional understandings which are embedded within the economic, social, cultural and political processes that can be revealed through a process of sense making.

The research participants drew extensively on their cultural cache as they constructed, applied, and transferred their lay models of health across generations. Culture matters in health – how people think and feel about health, and how they behave – is culturally constructed. While culture is not singly causal or determinate of health behaviour, it can be used as a toolkit of: “...symbols, stories, rituals and world-views which people may use in varying configurations to solve different kinds of problems” (Gregg & Saha, 2006b, p. 544). In this way “...health and illness are culturally constructed experiences that vary according to social context” (Manderson, 1990, p. xi). Similar to health and habitus, culture was found to be complex, mutable, embodied, non-reductionist, simultaneously consistent and flexible, transmittable across generations, patterned, operational in part at a level below awareness, influenced by the wider social and economic context, and able to both reflect and shape patterns of thinking and acting in the world. The next chapter describes a qualitative research paradigm and framework capable of delivering a study in the complex field of community health which is deeply embedded within embodied social experiences.

Chapter 3. Structuring the Field

In the first chapter, I placed myself within the study methodology, supported by a short autobiographical account. Next, the field of community health was reviewed and found health to be a multidimensional and embedded concept, which is at least somewhat accessible through a ‘corpus of stories’. With the aim of accessing the multigenerational constructs of health of a Finnish migrant community, of which I am a part, this chapter describes how a ‘corpus of stories’ was collected. A research paradigm capable of investigating the influence of embodied social experiences on patterns of thinking and acting with regards to health, by a researcher who is a member of the participant group, is described. The chapter is organised in two sections: methodology and methods. The methodology employs an interpretive research paradigm, and a constructivist theoretical framework underpins the ethnographic methodology. The methodology guided the selection of primary research techniques: participant selection, recruitment, ethical and cultural considerations, data collection and the general inductive and narrative approaches to analysis.

3.1. Research Paradigm, Framework and Methodology

The theoretical framework that underpins the ethnographic methodology is described and a conceptual summary is shown below.

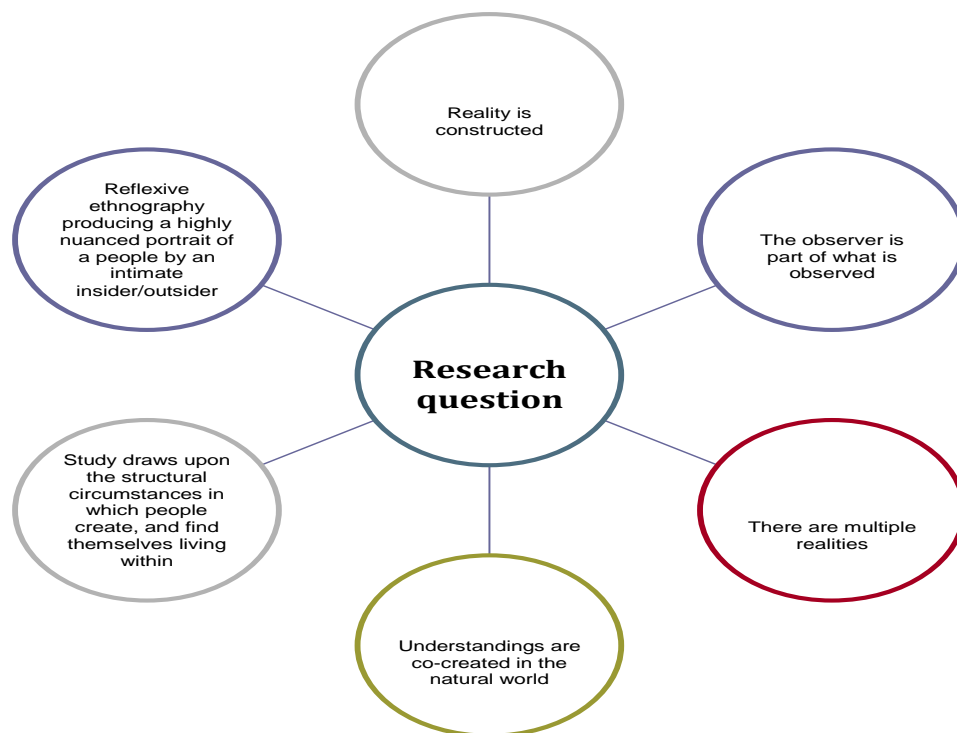


Figure 3 Conceptual Research Summary

All researchers have a personal set of understandings and feelings about the world, and about how phenomena should be studied and understood. These understandings are sometimes revealed by a researcher's ontology, epistemology and methodology, which reflect how the researcher sees the world and acts in it (Denzin & Lincoln, 2005, p. 140).

The underlying epistemology for this study is interpretive which views the world from the subjective experience of individuals, supported by the ontological understanding that reality is constructed and the observer is part of what is observed. The focus of research in an interpretive paradigm is on a pluralistic reality that is jointly constructed through human relationships and interactions, not a fixed ontological 'reality'. This contrasts with positivism which is concerned with objective reality and meanings thought to be independent of people. Coreil (2008, p. 108) proposed that the common denominator of interpretive approaches for health is: "...a focus on subjective, perceptual and cognitive dimensions of illness. It is concerned with a search for meaning, and assumes that these meanings are neither 'correct' nor fixed, but are negotiated through cognitive, social, and cultural filtering".

The interpretive paradigm is closely related to the constructivist framework selected for this study. While interpretivism is concerned with shared meaning and understanding, constructivism extends this concern by proposing that both knowledge and truth are as the result of perspective, and therefore all truths are relative to some perspective, context or meaning. Constructivism is orientated to the "...production of reconstructed understandings of the social world" (Denzin & Lincoln, 2005, p. 185) and constructivists posit that instead of objective knowledge, there are multiple and shifting realities (Appleton & King, 2002; Dressler, 2007; Guba & Lincoln, 1994; Reason, 1998). Constructivism is a theory of learning concerned with how people create meaning through individual constructs, and the types of filters through which people view their various realities. In this way, people are observers, participants and active agents who construct their own realities through reflexive processes. Denzin and Lincoln (2005, p. 25) proposed that the constructivist paradigm: "...assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent co-create understandings), and a naturalistic (in the natural world) set of methodological procedures".

Constructivists see:

...human behaviour as a function of how individuals impose a meaningful structure on the world around them and then behave in accordance with how they understand the world to be, regardless of how it might be structured and differentiated outside of their understanding (Dressler, 2007, p. 30).

This study investigates the constructed understandings of the social world through in-depth interviews, participant observation and other data collection techniques, as well as investigating the structural circumstances of migration and the policy environment. No matter what an individual's position in society (powerful or not), they are still constrained by their social position, even while acting in harmony with their personal understandings of socially-shared representations of their world. This dualist understanding takes account of: "...both how the world is configured by the collective meanings we impose upon it, as well as the social structure (and physical) constraints on our behaviour that exist outside those meanings" because: "Human health can be understood, in part, as the intersection of meaning and structure" (Dressler, 2007, p. 30). Dressler proposed, based on Bourdieu's (1990a) arguments, that: "...to understand human behaviour requires the analysis of the intersection of social structure and cultural construction" and that: "...research on culture, health and healing is a special kind of topical area in anthropology that virtually demands the integration of these perspectives" (Dressler, 2007, p. 39). This is also the case from a public health perspective, with Baum (1995) arguing that:

...knowledge is relative, its' understanding depending on the range of social and cultural factors. Thus, people's positions in society (class and power position, gender, culture) play a crucial role in their interpretation of events and facts.

The paradigm and framework supports an ethnographic methodology. Ethnography is a qualitative research methodology where fieldwork such as participant observation, interviews and document analysis are used to understand a way of life and what it is to be human (Gensuk, 2003). Ethnography is both method and genre because it describes both what is done and what is written. It is grounded in the experience of participants and, importantly in this study, of the ethnographer. The job of the ethnographer is to: "...evoke the sights, sounds, smells, tastes, and feel of a place, connecting audience to field informants through ethnography" (Sharman, 2007, p. 118). Fetterman (1998, p. 1) described ethnography as: "...the art and science of describing a group or culture". One hypothesis is that if we understand a group's culture we can develop theories of human behaviour for the particular group being studied, and also reveal general features of human social life. Others argue that ethnography is a 'portrait of a people' (Harris & Johnson, 2000); a written description of a particular culture, the customs, beliefs and behaviour, based on 'thick' or contextually rich information collected through fieldwork in naturalistic settings (Geertz, 1973; Gensuk, 2003; Harris & Johnson, 2000). The ethnographer both observes and is involved in the field of study; the methodology is particularly appropriate for studies of health perceptions, attitudes, practices, and patterns in different social and

cultural settings, such as those that exist for migrant groups (Liamputtong & Ezzy, 2005). Liamputtong and Ezzy (2005, p. 180) proposed that:

We have to admit that health is a complex issue involving many facets of a person's life. This, coupled with different notions of culture, means that we often 'know very little' about people's health and illness. For us, ethnography is the way in which a researcher may come to have an incisive and deep understanding about the people with whom they intend to work.

Being a member of the participant community as the daughter of a Finnish migrant, I considered how this impacted the process because the research field can lose its 'boundedness' when the lines between personal life and formal ethnography become blurred. This 'shadow side' of fieldwork can, however, be valuable in producing a highly textured portrait of a people (Leibing & McLean, 2007). In exploring the 'shadow side', the relationship between the production of knowledge and the ethnographer should be examined, in terms of: "...both what an ethnographer brings to the process of producing knowledge and how that process can impact subjectively and intellectually on the ethnographer (Lee, 2008, p. 150). Like Ergun and Erdemir (2010, p. 16), my experience of ethnography has been: "...a dialectical one that is continuously informed by the differentiating perceptions that researchers and informants have of themselves and others". Like Taylor, for me the field was: "...not only my site of work and learning, but it is my place of personal belonging, comfort, trust, friendship and love" (Taylor, 2011, p. 19). Taylor (2011, p. 8-9) used the term 'intimate insider' to describe researchers whose:

...pre-existing friendships (close, distant, casual or otherwise) evolve into informant relationships – friend-informants...Moreover, the notion of 'intimate insider research' can be distinguished from 'insider research' on the basis that the researcher is working, at the deepest level, within their own 'backyard'; that is, a contemporary cultural space with which the researcher has regular and ongoing contact; where the researcher's personal relationships are deeply embedded in the field; where one's quotidian interactions and performances of identity are made visible; where the researcher has been and remains a key social actor within the field and thus becomes engaged in a process of self-interpretation to some degree; and where the researcher is privy to undocumented historical knowledge of the people and cultural phenomenon being studied.

In certain circumstances, I have felt like an 'intimate-insider' as the daughter of a Finnish migrant who grew up in Kawerau knowing, to varying degrees, all of the study participants. While this 'native'

status gave me good access to participants because I was not perceived as being an ‘outsider’, it could also have presented a barrier to full disclosure in interviews because I knew too much and knew too many people in the community. However, Ergun & Erdemir (2010, p. 18) found that: “Informants tend to benefit from cultural proximity and so are willing to share information more easily”. My experience was that participants were open and generous with their sharing of themselves, even sharing sensitive information with me and trusting me to use it appropriately. I took this trust very seriously and have been careful to produce a thesis that is respectful and honours this trust my community placed in me. I was surprised at how some people I previously thought were quite reserved were prepared to share intimate details with me in the research interview, and how some people quite well known to me appeared initially nervous interacting with me in my ‘professional’ capacity. For participants who I knew but did not have a close relationship with, I have generally had some increased casual contact post interview encounter. For example: connecting on Facebook, catching up for coffee, stopping in the street to talk rather than just a wave. For participants who I knew and had a close relationship with, like Taylor (2011), I found that the instances of interviewing and data gathering were prolonged and contact was noticeably increased. This ‘intimate-insider’ status could also have resulted in a lack of objectivity and possible ‘insider blindness’. My mitigating approach was to make sure I did not rely overly on those close in relationship to me for data, ensuring a balance between participants close and not so close in relationship to me. This ‘intimate-insider’ status also introduced some personal risk for me. The consequences of people not receiving my research report well would be personal and could also affect my family.

In other circumstances I have felt rather like an ‘intimate-outsider’ as a university student, an interviewer, a professional, a woman, a second generation ‘child’. As I identified with more than one culture, I held “...mutually contradictory or mutually reinforcing values that the individual must somehow negotiate” (Gregg & Saha, 2006b). My insider/outsider identity has been in constant negotiation with participants, as the field operated in shadowlands that were neither unfamiliar, nor fully familiar, leaving me: “...suspended in a betwixt-and-between position...”, usually ending up with a fluid status that did not lead to either full inclusion or full exclusion (Ergun & Erdemir, 2010, p. 34). Taylor (2011, p. 6) proposed that: “...one can never assume totality in their position as either an insider or as an outsider, given that the boundaries of such positions are always permeable”. My ‘intimate insider/outsider’ identity was continually negotiated and provided both advantages and disadvantages, and shaped my personal and study experience. Taylor (2011, p. 9) proposed that:

Where the researcher-self is a part of the Other’s narrative, the narrative of the researched and the researcher become entwined. The researcher, then, is forced to look both outward and inward, to

be reflexive and self-conscious in terms of positioning, to be both self-aware and researcher self-aware and to acknowledge the intertextuality that is part of both the data gathering and writing processes. Moreover, the researcher needs also to be aware of the limitations of reflexivity, particularly as the relationship between knower and known is never unproblematic.

A reflexive approach revealed my betwixt-and-between position in the field throughout the research. Davies (2008, p. 4) defined reflexivity as:

...a turning back on oneself, a process of self-reference. In the context of social research, reflexivity at its most immediately obvious level refers to the ways in which the products of research are affected by the personnel and process of doing research.

Reflexivity is not a single phenomenon, but rather: "...assumes a variety of forms and affects the research process through all its stages (Davies, 2008, p. 7) "...without turning inward to a complete self-absorption that undermines our capacity to explore other societies and cultures" (Davies, 2008, p. 26). My reflexive experiences were documented throughout the study in both formal journals, and on whatever bits of paper came to hand when thoughts struck me. These experiences were then woven into the analysis and write up of the study. I found reflexivity resisted a planned approach – reflexive thoughts usually occurred while I was engaged in activities like driving, walking the dogs or showering and my mind was free to wander through the experience of my research while my body was performing a perfunctory task.

Throughout the study I was mindful that through the act of engaging with the participants in this research I was somehow affecting the phenomenon I was observing, and that my own beliefs and biases may impact others (Schneider, Elliot, Beanland, LoBiondo-Wood, & Haber, 2003). For example, in conversations post-interview with a number of participants the subject of health has come up (in a way that it had not before). I suspect that partly as a result of my position in a District Health Board, and partly because of our enhanced relationship post-interview, we discussed health issues that resulted, in some cases, in a particular course of treatment seeking. I tried not to turn each 'intimate' encounter into a data gathering exercise and to keep some boundaries between friendship and my role as researcher, but I found that a number of the participants had no such qualms about boundaries and took many opportunities to engage me in discussions related to the study. It seemed to me that they relished this new aspect of our relationship. Stories emerged unbidden, and I was often grabbed at social events by the arm to have a tale recounted – confidentiality flying out the window! There was a gendered

approach to these informal narrative interactions – the women tended to talk in groups and share their stories performatively with lots of laughter and physical touching, and the men tended to take me aside to have a private word in the corner, sometimes furtively looking around to see who was listening. My research appeared to spark a narrative flow in the community around health and migration, and this evidences the co-constructed nature of narrative. As usual, I documented these encounters on whatever paper came to hand, filed them in my field box, and used this data in the analysis phase of the research. This variety of non-fragmented sources of data – interviews, participant observation, document reviews, my memories over my lifetime, and social interactions – provided for a rich and thick ethnography. In this ‘intimate’ space my existing relationships evolved in some way and were changed as a result of the research. My thinking about health also evolved in some way as a result of the research process; my narratives and those of my participants became intertwined, highlighting the limits of reflexivity in my “...place of personal belonging, comfort, trust, friendship and love (Taylor, 2011, p. 19).

3.2. Primary Research Techniques

The methodology outlined in the previous section underpins this section which describes the primary research techniques employed for: participant selection, recruitment, ethical and cultural considerations, data collection and analysis.

3.2.1. Participants and Recruitment

My 25 participants came from three generations. The sampling approach was purposive, and aimed to: “...select information-rich cases for in-depth study to examine meanings, interpretations, processes, and theory” (Liamputtong & Ezzy, 2005, p. 52). Therefore, participants were selected only if they had specific characteristics of interest which were English-speaking (first or second language) people between the ages of 18 and 90 who met one of the following criteria:

- Gen1 - Finnish adults (at least 18 years of age) who migrated from Finland to Kawerau between 1954 and 1962
- Gen1.5 - children of Gen1 that were either part of the migrant group who came to Kawerau between 1954 and 1962, or who were subsequently born in New Zealand as children of Gen1
- Gen2 - children of Gen1.5

Eligible participants were identified through networking and snow-ball sampling methods. Networking was achieved through my knowledge of the Finnish community in the Bay of Plenty and in consultation with the three Cultural Advisors to the study: Paavo Sandberg (Gen1), Hannele van der Molen (Gen1.5), and Jason Viitakangas (Gen2). Snowball or chain sampling was used by asking participants to suggest other people who may be eligible and interested to participate in the research (Liamputtong & Ezzy, 2005). In addition, Koivukangas' Register of Migrants, compiled from immigration files, was used to verify eligibility according to the selection criteria. This Register was compiled when Olavi Koivukangas wrote his book on Finns in New Zealand, which included a chapter on the Kawerau Finns (Koivukangas, 1996). Initially I had planned to interview up to 30 people, but I got to the point after interviewing 22 people where I was satisfied that the data were rich enough to support analysis in the areas of interest. I interviewed three more people to satisfy myself that I had indeed reached theoretical saturation and also to even up the numbers of participants in each generation. This achieved the objectives of my purposive sampling approach because no new information (in terms of themes or new lines of inquiry) was forthcoming from the last three participants, and therefore redundancy was achieved (Guest, Bunce, & Johnson, 2006; Liamputtong & Ezzy, 2005).

Eligible participants were contacted by phone and asked if they would consider participating in the study. This procedure was selected in preference to initial contact by letter following advice from my Cultural Advisors who suggested this would be more appropriate because the participants knew who I was, or knew my family, and therefore a letter would be considered too formal as an initial approach. If eligible participants indicated interest, an initial meeting was arranged to discuss the research, ethical issues, written consent, confidentiality considerations, and to set up an interview date and time. Many of the eligible participants circumvented the initial meeting step during the first phone call, agreeing to be involved on the spot and encouraging me to just "come on over anytime and we do the interview then". Consequently, for most participants, providing information, gaining consent and interviewing was completed in one session.

A possible disadvantage of this method of recruitment was bias due to the sample group being related to, or known to, the researcher. There was a possibility that the eligible participants may have been reticent to disclose personal details even where robust confidentiality processes were in place. However, the pre-existing relationship and my 'intimate-insider' status proved to be an advantage to gaining access to this group and the participants willingly and openly shared their thoughts. To my

knowledge, two previous attempts had been made to interview this group as part of a research project but there was resistance by many to be involved as the researchers were not known to them. In addition, other articles and books on the Kawerau Finnish Community had been written in the past and some had felt they had been misrepresented or there had been inaccuracies in the publications which had made them wary of interviewing with people not known to them. As a consequence, the Cultural Advisors to the project were very concerned with accuracy in their review of chapters and even minor details and spellings were carefully discussed and edited in order to ensure a completely accurate representation so that: “people don’t have anything to say”. Review of chapters by my Cultural Advisors for accuracy and their thoughts, particularly on how my writing about issues might be received by the community, was supported by the dialogic nature of ethnography.

Four Gen1 participants that met the criteria declined to take part in the study when approached. Two had originally agreed but then changed their minds after reading the study material. One originally agreed but changed her mind due to her concerns about her English language ability, and it was true that the interview would have required significant translation. One other participant agreed to be interviewed if needed in order to complete the research, but preferred not to be interviewed. As the 25 participants elicited sufficient data, her wishes were respected and she was not interviewed. All Gen1.5 and Gen2 eligible participants who were approached agreed to take part in the study.

3.2.2. Ethical and cultural considerations

An ethical review was sought from the University of Auckland Human Participants Ethics Committee and approved on 18 February 2008 (Reference 2007/415) for a period of three years. Initially this was for a Master of Public Health on a part-time basis. Subsequently the study was expanded to a PhD on a part-time basis and the Committee approved an extension to 13/02/2013 (Reference 2007/415, see Appendix Two). Ethical issues related to human participants applied. These included: treating participants with respect and dignity; ensuring participants’ privacy, safety, health, personal, social and cultural sensitivities are protected; providing adequate and appropriate information to support informed and voluntary consent to participate; ensuring research methods are sound, and that the research has value that justifies participants’ time and input; disclosing conflict of interest issues; minimizing any possible harm that may result from participation through careful analysis of research procedures and robust support processes; freedom to withdraw participation or specific information during the study, and to receive feedback on the results.

In addition, there were some specific ethical and cultural considerations that required resolution. Because some potential participants were members of my extended family group, or known to me and/or my family, I resolved this issue through full disclosure of family connections in the Participant Information Sheet (see Appendix Three for all interview documentation). No issues resulting from my family connections came to my attention during the research. Another issue identified was that some translation from Finnish to English was required and family members were chosen to perform this translation. The rationale for selecting family members as translators was as follows: most of the participant group are related or known to each other and therefore selection of any member of the participant group would have raised similar ethical issues; the translators assisted throughout the project as Cultural Advisors and were already familiar with the study and the process of translation required; the translators were familiar with the provincial dialects of Finnish spoken by many of the participants and therefore were able to provide accurate translation; the translators were familiar with the language of what is colloquially referred to as 'Finglish' (new words amalgamating Finnish and English) which had developed among the participant group. For example, beachi (beach), Ronwellsille (Ron Wells is the name of a supermarket and the Finglish version translates as 'going to Ron Wells', icekriimia (icecream), omletti (omelette). I resolved this issue by outlining the translation process in full in the Participant Information Sheet. In addition, each translator was required to sign a Confidentiality Agreement (see Appendix Three) and translators were only given typed words or phrases to translate and were therefore not able to connect the words or phrases with any particular participant. No issues came to my attention as a result of the translation processes during the research.

I anticipated that the interview process may have resulted in participants feeling emotional or disclosing health issues or health concerns. I resolved this by identifying a process in the Participant Information Sheet for assistance, support and referral as appropriate. While there were some emotional times in the interviews, no apparent harm resulted and many of the participants told me they had found the process interesting and had enjoyed the opportunity to talk about their thoughts and experiences.

Participants were given the following documents to read prior to agreeing to participate: Participant Information Sheet, Consent Form, Interview Schedule, Questionnaire, Covering Letter and the Confidentiality Agreement for translators (see Appendix Three). Prior to signing the Consent Form the documents were discussed and an opportunity was given to participants to ask any questions i.e., the purposes of the study and potential benefits; what is required from each participant in terms of topics that will be covered; amount of time input required; what happens to the information provided i.e.,

confidentiality, anonymity procedures, translation procedures, who else would see the information, and destruction of identifying information. Participants were invited to take time to think about whether or not they were willing to participate and were advised on procedures for withdrawal should they wish to do so. They were advised that all data, including written, electronic and recorded tapes, were kept electronically secure through systems of passwords, using codes instead of names, backups, and kept physically secure by storage in a locked cabinet. Participants were given the opportunity to review their transcripts for accuracy. Only two participants responded with corrections to spelling of place names or names of people.

Participants were given the option of having their name appended to the research report as a participant due to a number asking if their names would be “in the book”. Participants’ names are not related to any data in the research report, and pseudonyms are used throughout. Two participants did not want their name recorded, and two were not sure so we checked ‘would not like name recorded’. The participant group is small, known locally and known to each other and this issue was discussed with participants and was detailed in the Participant Information Sheet. There was a risk that people would be able to connect information in the research report back to individuals in the community due to a shared history and on-going relationships. No participant indicated concern about their information, with many saying “everybody knows everything anyway”, but some did caution about confidentiality during the interview saying things like: “...now this bit has to be kept private” and: “...this is confidential anyway because I’m going to be nasty...”. My special thanks and acknowledgements of the contribution of participants are appended (see Appendix Seven).

Care was taken to report information in such a way that it presented a detailed and accurate representation of the social world of the participants, while simultaneously protecting the dignity of the participants, and of those people or activities described, by avoiding any harmful deductive disclosure¹⁵. Care was also taken to act from my ‘heart and mind’, acknowledging my interpersonal bonds with the participants, and to take responsibility for my actions and their consequences, including responsibilities to those alive and who have died (Ellis, 2007). Where there was a question in my heart or mind about the appropriateness of what was written in the thesis, I reviewed my writing with the participant or the family members of the person who had died to check that they were happy with what was written. In addition, the Cultural Advisors to the research assisted me by reviewing chapters and giving feedback on both accuracy and their thoughts on what was written. I was cautioned on a number

15 Deductive disclosure occurs when the traits of individuals or groups make them identifiable in research reports (Kaiser, 2009).

of occasions about how I had portrayed certain events through my writing and on those occasions we discussed ways of portraying events that were accurate but also sensitive to the people concerned. Given the dialogic nature of ethnography, the methodology supported getting feedback from participants and my Cultural Advisors throughout the research.

While no specific attention was given to a bi-cultural research strategy, I was cognizant of the need for a culturally safe approach to the research process. From my own knowledge and experience, and in discussion with my Cultural Advisors, areas that were considered included: taking off shoes when entering a house where the host is not wearing shoes; enquiring about family members and taking time to discuss my own family; accepting hospitality if offered i.e., cup of coffee / something to eat; being accepting of Finnish phrases and words (particularly relevant with first generation participants); greeting in Finnish, “Hyvää huomenta, mitä kuuluu” (good morning, how are you) or, “Hyvää iltapäivää” (good afternoon) where appropriate. Thinking specifically about cultural strategies presented me with a challenge because the things that others may term ‘culturally appropriate’ are just part of normal life.

3.2.3. Data Collection

The following approaches to collecting data were employed: administering a questionnaire, in-depth interviews, participant observation, a review of policy and archival materials including the diary of a participant’s father and books on Kawerau and the Kawerau Finns (James, 1979, 1985; Koivukangas, 1996; Moore, 1991), viewing a documentary given to me by a participant, my memories, and social interactions. The variety of data sources supported each other and provided for a rich and thick ethnography. While some approaches to data collection were planned (i.e., questionnaire, in-depth interviews, participant observation, my memories and thoughts, and a review of policy and archival materials) others emerged during the research process. For example, a participant gave me his father’s diary, another participant gave me a video documentary to watch, and unbidden stories emerged from social interactions.

The in-depth interview was selected as a data collection technique because it enabled exploration of the meanings people attach to illness as well as facilitating the discovery of people’s understandings of health (Baum, 1995). In addition, and drawing on the research methodology, interviews can involve creative engagement in ‘sense-making’ between the teller and the hearer/reader of narrative where:

“...respondents are not so much repositories of knowledge – treasuries of information awaiting excavation – as they are constructors of knowledge in collaboration with interviewers” (Holstein & Gubrium, 1995, p. 4). The in-depth interview technique in this study took a reflexive approach, where the narratives in the interview were co-constructed and thereby reality was subjunctivised through the encounter.

Buchbinder (2010, p. 111) proposed the notion that the listener has a critical role in the illness narrative, and stated that: “...social scientists have rather naively assumed that interviews afford a relatively unproblematic view of the inner world of the speaker” and that: “...rather than taking interview data at face value, the denotational content of narrative discourse must be situated within its pragmatic framework, in which the moral character of the protagonist is always at stake”. Reissman (2008, p. 23) described interviews as narrative occasions where the goal is to generate detailed accounts rather than brief answers or general statements, and proposed that: “The model of a ‘facilitating’ interviewer who asks questions, and a vessel-like ‘respondent’ who gives answers, is replaced by two active *participants* who jointly construct narrative and meaning”. Because the aim was to elicit narrative in interviews, the questions were simple, open and straightforward in order to create possibilities for narration. For example, the question “Tell me about your experience of migrating from Finland?” invited extended accounts. However, I found that emotional attentiveness and engagement with the participant was more important than the actual questions. I needed to give up a measure of control in the process, and was prepared to pursue the participants’ agendas even when it did not seem to ‘fit’ with the interview script, or the specific focus of the interview. Stories emerged at unexpected times, demonstrating the ubiquity of the narrative response (Reissman, 2008). For example, when I asked Gen1 Helvi what her highest educational achievement was (a seemingly straightforward question from the questionnaire) she answered: “Anyway, I start from the beginning...” and then told me the lengthy story of her early childhood, weaving her remembered schooling experiences into a narrative of the circumstantial misfortunes of her life, effectively taking control of the interview process.

My role as interviewer had no possibility of neutrality. Firstly, because I am: “...a person, historically and contextually located, carrying unavoidable conscious and unconscious motives, desires, feelings, and biases...” (Fontana & Frey, 2005, p. 696) and secondly, because of my intimate insider/outsider status. So then, I was forced to take a stance and on reflection, having stumbled clumsily into the interviews without giving the notion of stance a lot of thought, the stance I took was ‘Kerrie who is learning’. That is, I did not seek to deny existing relationships – I was Kerrie first - and still enacted

familiar relationship rituals, but I added a dimension to the relationship by revealing a new side of me many were not familiar with - that of a learner. The closer in relationship to me the participants were the more difficult it was for them to see me in this new role during the interview, and I perceived that Gen1 and Gen 1.5 found it more difficult than Gen2 who were closer in age to me. For example, Kaarina, a first generation participant very close in relationship to me, was uncharacteristically nervous at the start of the interview, often looking at the tape recorder as if it were a stranger sitting intrusively on the table, silently and judgementally eavesdropping on our private conversation:

Kerrie: The first question is how do you define health – so what do you think it means, you know, to be healthy.

Kaarina: What is means to be healthy? [Silence, silence, shrugs shoulders, looks at recorder, looks at door] It means to me that I get up in the morning feeling good because I have good night's sleep and then good enough to start the day's work with a happy mood, and that's how I think that I am healthy. [Looks at recorder] What else is there? [Shrugs shoulders, looks at recorder, look at door, shrugs shoulders, throws up hands, looks at recorder, nods to recorder, eyebrow arches at me, silence]

A number of the Gen1 and Gen1.5 admitted to me after the interview that they had been nervous, particularly about the tape recorder, and hoped they had “done well” and “given me what I needed”. A number of the Gen1 participants wanted to know if they had answered the questions correctly, and if I had all the information I needed to make a good book. A number also commented that it was strange to see me acting “all professional” and they forgot it was me half way through the interview. Despite the early nerves of some participants, my role as researcher/learner with a tape recorder and paperwork to be signed soon disappeared, and all warmed up quickly and the conversations flowed easily. The tape recorder did not seem to bother Gen2 and I did not detect any particular nerves. This could have reflected differences in life experiences in terms of previous exposure to the use of recording technology in interviews. This could have also reflected the “hush hush” notion of Gen1 discussed in Chapter Eight, where words recorded could be used against you and perhaps should not be talked about, having been influenced by World War Two experiences regarding secrecy. Most of the participants commented how they had never really talked about many of the issues we covered in the interview, and that they found it a satisfying and interesting process to explore those things. One Gen2 participant, who had never been to Finland, raised the idea of a trip to Finland with his family after the interview and told me later that the process of talking about his Finnish side opened up a new direction

in his family's life. My hope is that the interviews felt like a good conversation to the participants, where I was listening intently and contributing appropriately, and where we were able to explore issues together, and through that process, make sense of our lives which are connected in some way by our shared migrant history.

Participants were given the option of being interviewed at their own residence or at another place to be mutually agreed. All Gen1 opted to be interviewed at their homes. All but one of Gen1.5 opted to be interviewed at home, and one was interviewed at her parent's home because she lived overseas and was in New Zealand on holiday. Out of the nine Gen2 interviewed, only three opted to be interviewed at home. The rest were interviewed at various places that were mutually convenient including: two at their parent's home (as they lived out of town and were home for a visit), participant's place of work (1), my place of work (1), my home (1) and a quiet café (1). Each first face to face meeting (either at the initial meeting or the combined initial meeting/interview) usually started (and ended) with a period of 'small talk', catching up on family news, sometimes having a cup of coffee and generally settling into the process. Once the paperwork was discussed and consent formalities completed, the questionnaire was administered. The questionnaire was assigned a unique code and then completed at the start of the interview to collect demographic and other data, as well as a depiction of a family chart from the point of migration, which the participants drew. Where the completing of the questionnaire elicited narrative this was tape recorded and transcribed as part of the interview. The interviews were guided by a schedule of questions.

The schedule evolved slightly over the course of the interviews as new lines of inquiry emerged and were pursued with subsequent participants. One of these new lines of inquiry necessitated a follow-up question on aspects of spirituality and health with four of the Gen1 participants. The language in the schedule also evolved based on initial interview experiences. For example, I stopped using the word 'acculturation' in any context during the interviews early on, realising that this academic concept had no relevance in interviews which were attempting to understand how people made sense of their lives in their own, as opposed to an academic reality. As part of the development of the questionnaire and interview schedule, I practiced the interview process on my Cultural Advisors and integrated feedback prior to commencing interviews with the participant group. The interview schedule was translated to Finnish to assist those participants with Finnish as a first language in understanding the topic areas. The interviews were conducted primarily in English because of my limited ability to communicate in Finnish, other than at a conversational level. Just like Gen2 participants I interviewed my Finnish

language ability is, unfortunately, limited. The interview schedule was developed through review of relevant qualitative health studies, and from the original aims and objectives of the research (Ailinger & Causey, 1995; Elliot & Gillie, 1998; Haggman-Laitila, 1999; Haggman-Laitila & Astedt-Kurki, 1995; Thomas, 1999).

The arranged interview process (not including any follow-up visits) was generally completed within two hours. Immediately after every interview, usually in the car, I took notes on the interview experience which usually revolved around the sensory and emotional experiences of the interview. For example:

Strong Finnish accent...very Finnish home, lots of artefacts bought originally from Finland and also on trips back. Smells! Remember being here as a kid, just looks the same, like stepping back in time. Coffee...rugs...litala... Animated, funny, we laughed and laughed, time flew by. Also cried, so much tragedy, told so beautifully...have known her all my life but did not know about her life. A bird flew into the window, was it a sign?

These notes were also transcribed, but were not shared with the participants.

Only a few notes were taken during the interview process because I was fully engaged in the interview conversation. The interviews were audio recorded, transcribed verbatim (usually within 24 hours), and translation sought where required. Reissman (2008, p. 50) proposed that:

By our interviewing and transcription practices, we play a major part in constituting the narrative data that we then analyse. Through our presence, and by listening and questioning in particular ways, we critically shape the stories participants choose to tell. The process of infiltration continues with transcription...Transcribing discourse...is an interpretive practice. Representing 'what happened' in an interview is a 'fixation' of action into written form. Transcriptions are by definition incomplete, partial, and selective – constructed by an investigator...

“Transcription ‘flattened’ the interviews in many ways, even though I made transcription notes (recording pauses, silences and other markers) because texture such as speech cadence, accent and facial expressions were lost. The choices I made in how to display the speech in the transcription no doubt shaped my subsequent analysis. However, on analysis of the transcripts I could ‘hear’ each participant’s voice in the reading and it would transport me back to the interview encounter so the transcription approach, while ‘flat’, did provide some texture. Participants who indicated they would

like an opportunity to review the transcribed interviews and make any comments for the purposes of confirming the accuracy of the transcript, were sent the transcript within one week. Approximately one week following the posting of the transcript, I called, visited or emailed the participant as appropriate to discuss any feedback and make any changes. Changes were minor and were mainly spelling corrections to place names and names of people. Most participants were quite critical of their performance in the transcript, bringing my attention to their ‘ums’ and other speech idiosyncrasies. After similar feedback from the first few transcript reviews, I took time to prepare participants prior to interview when discussing transcript review, often making jokes about how I felt about seeing my own speech transcribed with all the ‘umms’ and rambling! I also explained why I left in those utterances and didn’t ‘correct’ the text i.e, for the benefit of a textured analysis. This appeared to put people at ease and gave us an opportunity to laugh about aspects of the transcript on review, reducing interview anxiety.

Finally, interviewing is not a passive neutral process where questions are asked and answered, and at the end the quest for facts and answers is fulfilled (Fontana & Frey, 2005). It is instead a dance that produces a mutually created story; a dance in which through knowing ‘others’ we come to know ‘ourselves’. Through this research process, my existing relationships with the participants were changed and deepened because we had created something together. My understanding of myself was changed and deepened because we had created something together. It was a rare privilege to engage in this ‘sense-making’ with members of a group with which I have a shared history. The questionnaire and arranged interview were not the only data collection methods. Multiple data collection methods provided additional rich data sources as well as ensuring credibility through data source triangulation (Baum, 1995). As discussed in 3.1 above, participants often told me stories relating to the study when we met at other times, as if they had forgotten to tell me something important in the interview and needed to get it ‘off their chest’. All the formal confidentiality processes were seemingly forgotten as they engaged me, and others around us, in stories about the early years in Kawerau, life in Finland, and their health and illness experiences. These stories, as well as my memories of past stories and events, were written up as soon as possible after the encounter on whatever pieces of paper came to hand, dated and stored in my field box and then reviewed and written up into the research where relevant. This work in the field supported the study methodology because working ethnographically with participants in their settings over time provides the best conditions for storytelling (Reissman, 2008). These informal interviews, as well as stories told to me over my lifetime, provided data for this study, as well as life-long participant observation in the Kawerau Finnish community. In that sense, data for this

study was collected by being in the field for 42 years, with a particular focus on health in the context of migration and policy for four years.

Adler and Adler (1994, p. 389) proposed that observation is: "...the fundamental base of all research methods" and Werner and Schoepfle (1987, p. 257) described observation as: "...the mainstay of the ethnographic enterprise". Data collected from observation at times presented analysis challenges where there appeared on the surface to be a difference between what people said (in the interview) and what people did (as observed). In her study of the parental accounts concerning health and the daily life of a California family, Garro (2010, p. 494) noted a difference between what people said in the interviews and what they actually did, and found that: "...it is essential that researchers go beyond a concern for the reproduction of official accounts and beyond what can be gleaned from interviews alone...". While there has been criticism that 'observer effects' introduce bias, "...some of the greatest strengths of ethnographic research lie in cultivating close ties with others and collaboratively shaping discourses and practices in the field" and observation: "...often reveal profound truths about social and/or cultural phenomena" (Monahan & Fisher, 2010, p. 357). This aspect of ethnography is demonstrated particularly in Chapter Eight where the embedded nature of health keeping is revealed.

I also became involved in doing things with the participants around health issues, such as attending doctor appointments, reading through patients' copies of doctors' reports and discussing the various processes around encounters with the health system. This could have been as a result of the enhanced relationship following the research process coupled with my job at a District Health Board and the nature of my study, which may have given participants the feeling that I was an 'interested expert' in health matters. Regardless of the reasons, I felt honoured to support my community in this way.

A couple of other sources provided data for the study. I was privileged to be given permission by Toivo Nurkka's son and daughter-in-law to use his diary in my study (see Appendix Four). Toivo, one of the 12 men to travel on the Captain Cook to New Zealand with his wife Aili and their five children, gave insight to life in Finland prior to migration as well as life in Kawerau from the perspective of a migrant. The diary commenced in 1947 and continued until Toivo's death in 1987, with the final diary entries being written by his son. The second source was a box of field notes and artefacts collected throughout the research process, including a diary written on my field trip to Finland in 2008. This practice supported a number of aspects of the research including on-going reflexivity - a way for me to

capture thoughts and experiences and keep them safe for reference later - and by providing an audit trail marking the journey of the thesis. I started out with good intentions at the beginning of the research process recording my thoughts regularly and transcribing them into a word document. That quickly became tiresome and felt contrived, so I started writing diary notes neatly in a notebook. That also quickly became tiresome and felt like a barrier to recording my thoughts with its uniform black lines, and so I started writing down thoughts, feelings, emotions, experiences and ideas on whatever bits of paper I could get my hands on at the time when the thought struck, and chucking them in a box when I got home.

My field box was an eclectic collection of: notes taken about casual conversations, recipes, observations, records of doctors' visits scrawled on the back of co-payment receipts, funeral notices, reflections on participation in community and family life on bits of paper, a DVD on the Finnish tango given to me by a participant that "shows what kind Finns are", CDs of Finnish music, reflections on the research process, photos, ideas on post-it notes, bullet point notes of family illnesses, newspaper clippings, emails, a few books, some receipts, a Lapland doll, half a plastic vial of pure cardamom (a key ingredient in Finnish baking), a book of Finnish poetry which is impossible to translate and understand, and memories of things from the past. I fossicked around regularly in my field box as I reflected on my thesis, popping the lid off the cardamom to smell it, listening to some Finnish music and riffling through random thoughts and memories, all the while weaving this precious collection of flotsam into my portrait of a people. I reproduced an example of a field note from the box, written on the back of a shopping list I found in my handbag, in the waiting room of a GP surgery, waiting for Sakari to pay for his consultation. Later I added to the note "felt good to be asked to help":

[Date] Doctor with Sakari. So good, treated with respect and caring, used voice and language well / not condescending. Been GP to Finns for a lot of years. ?? Has this made a diff to the older Finns health? Has one GP made difference?

In sorting my field box prior to embarking on my analysis, I used three categories: *substantive field data* which were descriptive and 'thick' (Geertz, 1973) in nature and recorded situations, events and conversations I had participated in or observed, sketches and drawings; *analytical field data* which were the notes I wrote up after each in-depth interview as described above; and *methodological field data* which were reflexive in nature, containing impressions, hunches, and random thoughts on the process and procedures of the study (Schneider et al., 2003). I then reviewed my field box data along with my other data during the analysis process and when writing up the research report.

3.2.4. Data Analysis

Two analysis methods were used in this study - general inductive and narrative – which allowed for deep probing of themes and supported triangulation of multiple sources of data. The systematic general inductive coding process was efficient for identifying themes and subthemes. During this process, metaphors, analogies, stories, poems and what was not being said, emerged and were highlighted for further narrative analysis. While a general inductive approach revealed themes, narrative probed those themes deeply, revealing additional layers through a ‘constructed’ view. Narrative analysis also revealed themes and provided a balance to the ‘destructing’ or ‘denarratising’ approach of the general inductive method with its breaking down of the interview transcripts in a search for themes..

A general inductive approach to data analysis was appropriate for this study as it provided an efficient and convenient way of identifying themes and subthemes, because: “Without thematic categories, investigators have nothing to describe, nothing to compare, and nothing to explain” (Ryan & Russell Bernard, 2003, p. 86). Themes developed from this inductive approach as well as an *a priori* approach which emerged from my prior theoretical understanding, informed by the literature review, my theoretical orientation, personal experiences and common sense (Ryan & Russell Bernard, 2003). The inductive approach to data analysis involved three stages: condensing raw interview data into summary format, establishing links between summary data and research objectives, and developing a theory about the underlying structure of experiences evident in the raw data (Thomas, 2006). The raw data from the questionnaire were entered into a spread sheet (Microsoft Excel) in a common format. Identifying information was removed and pseudonyms substituted for participant names. The data were then summarised and analysed.

The raw data from the interviews were audio recorded, transcribed by me, checked by participants who requested a review, translation provided where required, and post interview notes included. The transcripts were then read in detail at least twice until I became familiar with themes and events, using different coloured highlighters and underlining to assist with this process. I then commenced coding with a trial version of NVivo (analysis software), but felt it disconnected me from the words of the participants – I found I preferred to sit on the floor surrounded by paper, literally ‘destructing’ the transcripts with scissors! Text was instead coded manually, categories were created from the text (code reduction), and themes emerged from the categories. High level categories identified general themes that followed from the high level research objectives. Low level categories developed from coding the text. Coding overlapped in some instances as portions of text were coded to more than one category.

Some text was not coded if it was of no relevance to the research objectives. Some categories were combined or linked as part of the process. The goal of the process was to create between three and eight categories that captured the key themes expressed in the interviews, as they related to the research objectives. Key categories emerged through repetition as the themes appeared a number of times within and across transcripts. Metaphors, analogies and stories also emerged in this phase and were highlighted for further narrative analysis. I also reviewed the transcripts for missing data - for what was not being said.

As described in the previous chapter, people use narrative to engage in sense and meaning-making, and through this process they work out their place in the world and how to live meaningful lives. Our lives, then, are the remembered pasts we tell ourselves, and stories both reveal and construct our identity (Harter et al., 2005; Ochs & Capps, 1996; Sarbin, 1986; Smith & Sparkes, 2008; Spector-Mersel, 2011; Van De Mierop, 2009; Watson, 2008). Hendry said:

...through telling our lives we engage in the act of meaning making. This is a sacred act. Stories are what make us human. Our narratives...are the tales through which we constitute our identities. We are our narratives (Hendry, 2007, p. 495).

Narrative analysis was selected in order to capture the participants' lived experiences through investigation of the stories they told me during interviews. Narrative analysis also fits well with the ontology and epistemology of the study, being an interpretive/constructivist design (Josselson, 2006; Spector-Mersel, 2010).

Narratives are versions of reality, not omniscient accounts (Ochs & Capps, 1996) and people use narrative to: "...remember, argue, justify, persuade, engage, entertain, and even mislead an audience" (Reissman, 2008, p. 8). Narrative and self are inseparable because narrative is both born out of experience and give shape to that experience (Ochs & Capps, 1996) and: "Each narrative organises a vector of experience along a temporal horizon that spans past, present, and possible realms" (Ochs & Capps, 1996, p. 37). Narratives are also social – they are 'done' or 'told' in social interactions and are shaped by socio-cultural language conventions. Narratives also 'do' things such as provide moral force and accomplish social status (Smith, 2007); they made a normative point and they draw on a cultural stock of plots (Polletta, Chen, Gardner, & Motes, 2011).

Spector-Mersel (2011, p. 172) reflected that:

Since the ‘narrative turn’, the narrative has been extensively discussed: as a cognitive scheme, an organising principle of reality, a reflection and creator of self and identity, a means of interaction, even a kind of intelligence. Compared with this elaborate theorisation, the corpus dealing with the practical tasks of interpreting narratives has remained notably undersized. Despite valuable contributions regarding the ‘hows’ of narrative research, analysis of stories seems nonetheless to be the most underdeveloped aspect of narrative scholarship.

As a result of this relative underdevelopment, my approach to narrative analysis for this study draws on a mix of recent approaches proposed by Reissman (2008), Smith (2007), Gubrium & Holstein (2009) and Spector-Mersel (2011). The approach adheres to a number of basic principles as described by Spector-Mersel (2010, p. 214):

Treating the story as an object for examination, not as a neutral pipeline for conducting knowledge that is ‘out there’...Following the narrative ontology that emphasises the story’s holistic nature, narrative analysis is based on a holistic strategy in four major senses: (1) Adopting a multidimensional and interdisciplinary lens... (2) Treating the story as a whole unit... (3) Regard for form and content... (4) Attention to contexts.

Smith (2007) commented that narrative inquiry can mean different things to different people, and that like the stories themselves, multiple perspectives are required. He discussed two approaches to narrative – formulaic and playful. The formulaic approach utilises highly standardised procedures and analysis in an attempt to unlock or crack the narrative code. The approach to narrative analysis in this study is playful which may or may not apply standardised procedures, and attempts to play with ideas and narrative in an artful manner. Just because a story does not adhere strictly to story-telling conventions does not mean it is not narrative (Gubrium & Holstein, 2009) and stories do not always need to be an analysis of one complete utterance, ‘small stories’ told to me in social situations provide rich narrative opportunities for this study.

Narrative analysis refers to: “...a family of methods for interpreting texts that have in common a storied form” according to Reissman (2008, p.11). However, just because a story does not adhere strictly to story-telling conventions does not mean it is not narrative (Gubrium & Holstein, 2009).

Adams (2008, p. 176) asserted that: "...in the telling of stories¹⁶, we abide by story-telling conventions such as the use of common storylines, linear or chaotic temporal sequences, and writing within/against genres". This sequence of action distinguishes that narrative analysis is interested in both how and why narrators 'story' their experiences, not simply the language content. Reissman (2008, p. 11) asked:

For whom was *this* story constructed, and for what purpose? Why is the succession of events configured that way? What cultural resources does the story draw on, or take for granted? What storehouse of plots does it call up? What does the story accomplish? Are there gaps and inconsistencies that might suggest preferred, alternative, or counter-narratives?

Narrative analysis, therefore, shifts from the 'destructing' or 'denarrating' approach of the general inductive method in its search for themes, and instead views narratives as wholes, focussing on the particularities and context of the story. While this analysis method can also produce themes, the focus is on prompting the reader to think beyond the surface of a text, and to move toward a broader commentary (Reissman, 2008). This seemingly contrasting approach was resolved in this study by a separation of analysis methods. The general inductive approach revealed themes, and the narrative approach probed those themes deeply, revealing additional layers through a 'constructed' view. The specific approach to narrative analysis in this study was adapted from Reissman's (2008) dialogic/performance analysis and supported by Spector-Mersel's (2011) approach. Reissman (2008, p. 105) proposed that dialogic/performance analysis: "...interrogates how talk among speakers is interactively (dialogically) produced and performed as narrative" which:

...requires close reading of contexts, including the influence of the investigator, setting, and social circumstances on the production and interpretation of narrative. Simply put, if thematic and structural approaches interrogate 'what' is spoken and 'how', the dialogic/performative approach asks 'who' an utterance may be directed to, 'when' and 'why' that is, for what purposes?

The performative aspect of narrative views storytelling as a stage through which identity is dramaturgically realised and presented. In this frame narrative is animated - it transpires somewhere, for some audience, for some purpose. There are characters, scenes, and presentation effects. The focus of this approach is on how social circumstances figure in storytelling. This includes the context (or social dimensions) in which stories are created, including the circumstances, conditions, goals of

¹⁶ Like Reissman (2008, p. 7) I use the terms 'story' and 'narrative' interchangeably.

accounts, and what is remembered in what way. This also includes how the interviewer (and eventually reader) becomes an active participant in the narrative. At different times, at different places and with different audiences, stories can be performed differently (Gubrium & Holstein, 2009; Reissman, 2008). Within this narrative environment:

...one can't be a 'self' by oneself; rather, identities are constructed in 'shows' that persuade. Performances are expressive, they are performances *for* others. Hence the response of the listener (and ultimately the reader) is implicated in the art of storytelling (Reissman, 2008, p. 106).

Spector-Mersel (2011) proposed three aspects of context as important for narrative analysis. Firstly, the macro context, being the social, political and economic conditions within which the narrative is produced. Secondly, the micro context, being the narrow conditions of the narrator's life including mood and events that occurred recently or will occur soon. Thirdly, the immediate context, being the circumstances of the narrative production including time, place, interviewer, setting and questions. She also proposed that other contextual forces should be taken into account including: cultural key plots, social factors (gender, status, age, ethnicity, sexuality, psychological motivations) and cognitive biases. All these factors reveal a holistic approach to narrative analysis which, according to Spector-Mersel (2011, p. 175), is the signature of narrative analysis and is:

...carried out within a complex web of influences, bringing together individual, society, and culture; inner and outer worlds; free choice and limiting factors; past, present, and future...(Spector-Mersel, 2011, p. 173)

The approach for this study also considers the role of selection (the process by which participants select part of their life history to develop in their narratives) and what Spector-Mersel (2011, p. 174) termed "end points", being the central point of the story being told. She (2011) proposes that once the end point has been selected, the narrator selects relevant events from his/her life history that make the central point probable and through this process decisions are made about what to include and what to leave out. Six deductive mechanisms of selection by narrators are described by Spector-Mersel, and are likened to the functions performed by a photographer, where the following 'editing tools' are used to mould life histories into meaningful stories (2011, p. 174-175):

- Inclusion refers to representing facts, events and periods of the narrator's life history that are compatible with, and therefore confirm, the end point;

- Sharpening occurs when some of the above inclusions are given prominence;
- ‘Appropriate’ meaning attribution occurs when significance is conferred on certain facts and events that support the end point;
- Omission is where certain facts and events are not reported because they are irrelevant to the end point;
- Silencing is where certain facts and events are not reported because they contradict the end point;
- Flattening minimises certain facts, events or periods for similar reasons as omission or silencing above, or as an outlet for ‘narrative difficulty’ where two themes in the narrative clash.

In contrast to the narrator who performs a deductive process by first setting an end point and then selecting facts and events to confirm and support it, my analysis process is inductive as I search for the end point by examining the ‘editing tools’ used by the participants in their telling of stories.

The findings from narrative analysis are then presented through both ontological narratives and epistemological narratives. Ontological narratives being: “...those that look at the ways in which we, as individual narrators, come to understand and articulate our social “reality” (Harling Stalker, 2009, p. 223) and epistemological narratives where the focus moves from the participant to the researcher and: “...the researcher’s understanding and ideally reflexive interpretation that becomes a particular story of a particular social world” (Harling Stalker, 2009, p. 230) (see also Riessman’s (2008, p. 6) discussion of narrative layers). While the stories that emerged through the interview conversation did not necessarily fit neatly into the theoretical constructs described above, they nevertheless provided a powerful insight into the experiences and beliefs of the participants in the study.

3.2.5. Validity

The issue of validity has been the subject of considerable debate, both in terms of whether the concept should be applied to qualitative research and, if so, what criteria should be used. A number of conceptual and theoretical approaches have been proposed and existing literature has found that validity can be defined in a number of ways, and operate based on a number of epistemological and theoretical variations (Hannes, Lockwood, & Pearson, 2010; Koro-Ljungberg, 2010; Whitemore, Chase, & Mandle, 2001). Some researchers have proposed that translations of the validity concept

from quantitative to qualitative research include: rigor, trustworthiness, plausibility, credibility, authenticity, confirmability, internal coherence as well as others (Eisner, 1991; Guba & Lincoln, 1989; Koro-Ljungberg, 2010; Lincoln & Guba, 1985). These proposed translations have been alternately criticised and supported (Sandelowski, 1986; Seale, 1999). In support, Golafshani (2003, p. 604) proposed that: “Reliability and validity are conceptualised as trustworthiness, rigor and quality in the qualitative paradigm” and that through triangulation bias can be eliminated and the truthfulness of a proposition about the social phenomenon being researched can be increased. Creswell and Miller (2000, p. 126) defined triangulation as: “...a validity procedure where researchers search for convergence among multiple and different sources of information to form themes or categories in a study”. As already described above, I have used method and data source triangulation in my research. In addition, Cultural Advisors and participants have provided feedback throughout the research process.

Aguinaldo (2004, p. 127) theorised the issue of validity from a social constructivist perspective and found that: “...validity of research is no longer conceived as a determination (i.e., “is valid” versus “is not valid”) but a continual process of interrogation”. Taking up this approach, my research replaces the question “is this valid research?” with “what is this research valid for?” and therefore a focus on validity in context runs as a thread through the study. This study also takes an argumentative approach as described by Polkinghorne (2007, p. 471) who identified two threats to validity in narrative research as: “...the differences in people’s experienced meaning and the stories they tell about this meaning, and the connections between storied texts and the interpretations of those texts”. He also proposed that validation of narrative research claims is an argumentative practice that aims to: “...convince readers of the likelihood that the support for the claim is strong enough that the claim can serve as a basis for understanding of and action in the human realm” (2007, p. 476), as opposed to a mechanical process. The rationale being that narrative research searches for narrative truth; how people understand situations, selves, and others as opposed to the search for historical or factual truth. Therefore, the validity process does not produce simple acceptance or non-acceptance responses; rather it is a rhetorical function that seeks to make persuasive arguments to convince readers of the likelihood that the claims are valid through a systematically argued research report. This argumentative practice pervaded both the collection of evidence and the analysis of the evidence in this study.

3.3. Summary

This qualitative study was conceived within an interpretive paradigm, where reality is constructed and the observer is part of what is observed (Lahtinen, Koskinen-Ollonqvist, Rouvinen-Wilenius, Tuominen, & Mittelmark, 2005). The study framework is constructivist because it is orientated to the: "...production of reconstructed understandings of the social world" (Denzin & Lincoln, 2005, p. 185). Through narrative, my participants attempted to make sense of their lives in time through this interpretive framework; they remembered how and why things had happened in the past, and they linked that remembered past to their present as they explored how this might shape their future. In this way, the study framework allowed participants to describe their lives in time; "...a life is not 'how it was' but how it is interpreted and reinterpreted, told and retold (Bruner, 1987, p. 31). In this way, the past and present are often reworked through the constructivist telling process where people in a process of 'becoming' by organising the past and anticipating future possibilities through narrative (Mattingly, 1998; Ochs & Capps, 2001). The framework also allowed the study to draw upon the structural circumstances which the participants created, and also found themselves living within (see particularly Chapters Four and Five). The study structure supported a highly reflexive ethnographic methodology by an 'intimate insider/outsider' where a variety of data sources were used to understand a way of life and what it is to be human (Gensuk, 2003).

Delving deeply into what people think, feel and do required both ethnographic and narrative approaches; multiple data sources elicited rich and 'thick' data and the concept of health was at least somewhat accessible through a narrative 'corpus of stories'. Through narrative, participants in the study were able to make sense of their experience of health, giving it meaning and signification, within the wider economic, social, cultural and political contexts of their life experiences. Method triangulation was achieved through two methods of data analysis, general inductive and narrative. One method without the other would have been challenging; the two analysis perspectives allowed for deep probing of themes and supported triangulation of the multiple sources of rich data. The general inductive approach provided an efficient and convenient way of identifying themes and subthemes through coding. In contrast, the narrative approach was holistic and playful: adopting multidimensional and interdisciplinary lens, treating the story as a whole unit, having a regard for form and content, and paying attention to contexts (Spector-Mersel, 2010, 2011) as well as the performance of the narrative (Gubrium & Holstein, 2009; Reissman, 2008). While a general inductive approach revealed themes, narrative probed those themes deeply, revealing additional layers through a 'constructed' view. Narrative analysis also revealed additional themes and provided a balance to the 'deconstructing' or 'denarratising' approach of the general inductive method. Narrative was useful for discovering how the

participants' used their remembered pasts to make sense of their world and construct their identities (Harter, Japp, & Beck, 2005; Ochs & Capps, 1996; Sarbin, 1986; Smith & Sparkes, 2008; Spector-Mersel, 2011; Van De Mierop, 2009; Watson, 2008) influencing their understandings and health keeping practices. Narrative was particularly useful for this study where I was part of the community, allowing me to analyse the stories that emerged unbidden at times other than the formal interview process as data for this ethnography. The findings from narrative analysis were presented through both ontological and epistemological narratives (Harling Stalker, 2009). As well as method, data source and validation with Cultural Advisors and participants, validity was achieved through interrogative and argumentative approaches which ran as a thread throughout the research process from data collection to analysis.

The methodology and methods described in this chapter provide a framework to investigate the multidimensional Bourdieusian (1990b) 'field of health' described in Chapter Two, which is embedded within unique social and economic factors. The next chapter explores how policy, as one of those factors, may have influenced how participants think, feel and act in their field of health in the light of their migrant and multicultural experiences.

Chapter 4. The Structuring Influence of Policy

Through an exploration of the field of health in Chapter Two, concepts of health, lay models, health behaviour and health/illness narratives were found to be embedded within economic, social, cultural and political processes. In addition, habitus was found to be enabled by various forms of economic, cultural and social capital which provide players ‘in the game’ with resources and power (Bourdieu, 1986; Bourdieu & Wacquant, 1992). This chapter explores the embedded nature of health through a review of policy, illuminating how political processes influence peoples’ histories and experiences, and how policy can provide various forms of capital which can influence how people think, feel and act in the field of health. It also discovers the impact of appearing ‘British-like’ in policy, despite having a unique non-British migrant history. In the Bourdieusian sense, it provides for an exploration of health through the intersection of structure (policy) and meaning (ethnography and narrative). As well as contributing to the theoretical base outlined in Chapter Two, this chapter achieved one of the objectives of the study by investigating the influence of policy on patterns of thinking and acting in the field of health across generations, and within the context of migration.

4.1. Migration Policy

Migration is a growing phenomenon (United Nations, 2008) and countries develop policy to manage the implications of the “age of migration” (Castles & Miller, 2003, p. 1). Migration policy is concerned with fundamental issues of sovereignty, national identity and security (Martin, 2001). While I use the term ‘migration’ and discuss policy issues of immigration and migration concurrently, they are in fact two separate but overlapping concepts. Immigration policy has a focus on the rules and regulations that govern inflows to the host country, and migration or settlement policy has a focus on how migrants are ‘managed’ once they have arrived, including how the relationships between the host and the migrant are ‘managed’ (IOM, 2008; OECD, 2008). This section describes the policy in Finland and New Zealand that shaped the migration, and subsequently the health, experience of Gen1 and Gen1.5 (being the two generations who migrated from Finland in contrast to Gen2 who, while still affected by a migrant history, were born in New Zealand).

4.1.1. Finnish Migration Policy

Finnish migration policy provided the participants with economic capital by presenting no barriers to emigration for Finns in search of post-war employment. The participants also accrued culture and social capital through the effects of policy because emigration was considered a norm in Finland when

they left, although they pushed the boundaries of this capital because New Zealand was considered very far away. An ameliorating effect was the short length of the Tasman contracts with the promise of a return trip home, which gave them the cultural and social cache of being on an adventure from which they could return should they so desire.

In the 1950s, Finland was one of the most ethnically homogenous countries in Europe with less than 2% of the population identified as non-Finnish. By 2003 this had risen to only 3% (Statistics Finland; Tanner, 2004; Visit Finland). While there has been relatively little immigration, Finland has a notable history of internal migration and emigration (Solsten & Meditz, 1988). Finland can be described as a nation of emigrants with around one million Finns emigrating between 1860 and the Second World War (Korkiasaari, 2005). There have been no restrictions on Finnish emigration in law at the date of writing this thesis. Up until the 1990s emigration consistently exceeded immigration and so it is no wonder that Koivukangas (1996, p. 9) commented: “You can hardly find a place on earth where there aren’t any Finns”. This pattern of emigration had a detrimental effect on the population of Finland; post Second World War Finland’s population growth had been among the lowest in the world as a result of low birth rates coupled with high levels of emigration (Solsten & Meditz, 1988, Demography). Neighbouring Sweden received approximately 550,000 Finns post Second World War, and the steady stream of emigrants to Sweden from the sixteenth century up until the 1970s became somewhat of a national tradition. Emigration to Sweden peaked at 41,000 in the 1960s and 1970s as people searched for employment, although some of those migrants subsequently returned to Finland as the economy improved (Koivukangas, 1996, 2005; Solsten & Meditz, 1988; Tanner, 2004).

Finns emigrated to other northern hemisphere countries as well such as Norway, Denmark, Central Europe and Russia, but not in such great numbers. Most emigration outside of Nordic countries was to North America, receiving around 500,000 Finnish migrants. Only about 40,000 Finns chose southern hemisphere countries with New Zealand receiving around 2,000 Finns in total. Prior to the Second World War Finns mainly emigrated to Canada and the United States. When the United States adopted strict quota rules, Finns began to emigrate to Canada and Australia, but in smaller numbers. Of over one million emigrants since 1860 Koivukangas (2005, p. 201) asserted that: “no more than 40,000 chose Latin America, Africa, Australia, New Zealand or Asia.” Out of these countries, Australia was the most popular destination, partly as a consequence of the North American restrictions, as well as an assisted passage program. Around 20,000 Finns made their way to Australia after the Second World War (Koivukangas, 1996, 2005; Tanner, 2004). Koivukangas (2005, p. 192) stated that: “...altogether

the number of Finns who have moved to New Zealand during the past 150 years could be estimated at 1500-2000 persons, the lower figure referring to permanent settlers and the latter figure including short-term residents”.

In contrast to a long history of emigration, Finland’s history of immigration is very recent, spanning only the last few decades (Alitolppa-Niitamo, 2004; Paananen, 2005; Pentikäinen, 2005). As a consequence, policy development has been relatively recent and the immigrant policy focus continues to be on integration into Finnish life. For most of the 20th century, Finland had been a largely monocultural country (Forsander & Ekholm, 2001) and Finns had not traditionally been accepting of foreigners. National and local policies and attitudes were slow in responding to the changes in the ethnic makeup of Finland (Kosonen, 2008; Pentikäinen, 2005). This non-acceptance could have stemmed from years of foreign rule pre-independence, as well as a fear of foreigners on Finnish soil during periods of war. However, over time, public opinion became more accepting of migrants and recently immigration has been encouraged by the government to boost the workforce. It appeared, however, that this gradual acceptance varied by ethnicity. A 2005 study comparing the attitudes of Finns towards immigrants from 24 different countries found that the most positive attitudes were held towards the British, and the most negative attitudes were held towards Somalis (Jaakkola, 2005). When Gen1 and 1.5 left Finland in the 1950s they were likely influenced by the largely monocultural view prevalent at the time, however, despite this, they reported they were very interested in, and accepting of, the many different nationalities that lived in Kawerau when they immigrated.

4.1.2. New Zealand Migration Policy

New Zealand migration policy provided the participants with economic capital through the right to live and work in New Zealand, however, there was no migration assistance or settlement programme to accompany the welcoming immigration policy. Cultural and social capital also resulted from a history of migration policy, where ‘British-like’ migrants were welcomed, particularly in the multi-cultural town of Kawerau.

In contrast to Finland, New Zealand has historically been known as a settlement country, receiving relatively large numbers of migrants over time along with Australia, Canada and the United States. Immigrant populations in OECD countries have more than trebled since the 1960s (OECD, 2008, 2009). An OECD (2009, p. 66) report on social indicators found that:

The share of the foreign-born was highest in Australia, Canada, Luxembourg, New Zealand and Switzerland, where it was 20% or more...and that some countries, including New Zealand at 4%, have registered very high changes in the immigrant share of the population evidencing a rapid growth rate in foreign-born population shares.

The New Zealand Department of Labour (2006) reported that in 2006 one in five New Zealanders, or 20% of the population, were born overseas compared to around 14% in 1956. Statistics New Zealand (2007) predicted New Zealand will have even greater ethnic diversity in the future. A report publishing the first results of the New Zealand Longitudinal Immigration Survey in May 2008 proposed that: "...immigration is critical to New Zealand's economy and national identity" and that it: "...strengthens families and communities, enhances social and cultural diversity, and promotes New Zealand's international interests" (Immigration New Zealand, 2008, p. 1). The report further argued that: "...with about 20 per cent of New Zealanders born overseas and 25 per cent of migrants in New Zealand's workforce, New Zealanders recognise immigration's importance and see it as a vital part of our culture" (Immigration New Zealand, 2008, p. 1).

Unlike the emigrant nation of Finland, New Zealand can rightly be described as a nation of immigrants. Immigration to New Zealand began with the trans-oceanic migrations of Polynesian peoples 1,000 years ago, to the arrival of the colonists from Great Britain and northern Europe in the 19th century, to today's net migration gains that continue to shape New Zealand society in the 21st century. For more than a century prior to the 1970s, government policy had a focus assimilating European migrants and the indigenous Maori (R Bedford, Ho, & Lidgard, 2000). During the 1970s the ideological focus shifted from assimilation to biculturalism, and today the focus is on multiculturalism and a policy of social cohesion. While the assimilation and bicultural focus were reflected in policy, multiculturalism was not (R. Bedford, Ho, & Lidgard, 2001). Prior to 1986 immigrant acceptance in policy was based on the perceived desirability of cultural background, and the perceived ability to assimilate. In 1986 there was a policy shift towards how the immigrant would benefit New Zealand's economy and this, along with continued acceptance of refugees, resulted in an increase in the cultural diversity of immigrants. This somewhat rapid increase in cultural diversity spawned public and political debate on immigration policy, and the impact on New Zealand society (Spoonley, Peace, Butcher, & O'Neill, 2005).

Unlike Finland's relatively recent migration policy history, New Zealand migration policy dates back to 1840 when New Zealand became a British colony through the signing of the Treaty of Waitangi (D

Green, 2009). Immigration policy in New Zealand has evolved from open entry, to a somewhat discriminatory restriction of entry, to the current policy of acceptance based on a number of principles designed to enhance New Zealand's economy and society. Beaglehole (2007, p. 1) summarised that:

In the early 19th century, New Zealand's doors were open to all. But in 1881 the first barriers were set up, to hold back Chinese immigrants. By the 1920s, it became harder for anyone who was not British to get in. Russians, Italians, Japanese, Africans – people from all over the globe faced restrictions. There was a 'White New Zealand' policy in practice, if not in name. By the end of the 20th century, however, other conditions were applied to immigrants, such as whether they had job skills or financial assets, or were in need of refuge.

Bedford (2003, p. 1) asserted that the demographic domination of Maori in New Zealand: "...ended during the second half of the 19th century when colonists from Great Britain and northern Europe arrived in their tens of thousands to create a new "Britain" in the south seas". Before and after the signing of the Treaty in 1840, entry to New Zealand was unrestricted in policy. From 1840 until 1948 under the British Nationality and New Zealand Citizenship Act, most people in New Zealand were officially British subjects. Up until the passing of the New Zealand Citizenship Act in 1977, there was an attempt to create a common citizenship code across the British Empire, and it would take until this Act was passed to formally separate citizenship by country and to remove the description 'British subject' from passports (D Green, 2009). After the signing of the Treaty, non-British migrants were classed as 'aliens', and not all aliens were treated equally. Some groups, who were considered 'undesirable' immigrants were subject to prejudice both in policy and practice (D Green, 2009). By 1881 'alien' status had been formalised by placing restrictions on non-British migrants, particularly Asians (Beaglehole, 2007). Beaglehole (2007, p. 1) explained that: "Making New Zealand British and keeping the country white were the goals of immigration policy until the early 1970s. People from Britain have been actively recruited, while people perceived as 'different' have been kept out". This policy effectively advantaged Finnish migrants who were considered 'sufficiently British-like' to be acceptable in policy.

In 1920 the Immigration Restriction Amendment Act was passed with the aim of further restricting Asian immigration to New Zealand. By the 1970s entry for Asian people was much less restrictive, although policy aimed at limiting the immigration of certain groups in order to preserve a 'racial balance' in New Zealand to promote 'harmonious' intergroup relationships persisted. Ethnic groups seen as less likely to integrate, and more likely to form their own ethnic communities, were considered

less desirable from the perspective of social cohesion. Desirable immigrants were those from European countries with social and cultural heritage perceived as similar to 'British' New Zealand, and therefore more likely to assimilate, such as the Finns. Europe was not viewed as a homogenous group however; Eastern and Southern Europeans were considered less desirable than Western Europeans. Legislation in the 1980s ended the discriminatory race-based immigration policy (Beaglehole, 2007; R. Bedford et al., 2001). Trlin (1986) argued, however, that while discriminatory policy was no longer overtly stated, it persisted in a more subtle and covert forms through the wording and operation of entry provisions (see also Beaglehole (2007)). In policy and practice, the Finns have been viewed as desirable immigrants throughout their lives in New Zealand, despite changes in policy. This provided them with significant social and economic resources and illustrates how, through policy, capital can be provided.

The distinction between British and other settlers stems back to the mid-19th century when aliens (non-British settlers) were free to live in New Zealand, but their property rights were restricted. The alien settlers complained and from 1844 aliens could become naturalised subjects through ordinances, which were later replaced by an annual naturalisation act in 1854 when New Zealand became self-governing (D Green, 2009). Green (2009) asserted that "The Treaty of Waitangi had authorised settlement by 'people of [the Queen's] tribe'; extending the right to become British subjects to people other than natural-born British subjects was, in a sense, an early breach of the treaty". There is on-going debate on how the Treaty of Waitangi relates to the regulation of immigration. Some Maori have argued that the intent of their ancestors was to only allow immigration from the countries named in the preamble to the Treaty, and that any immigration legislation or policy should be discussed with Maori as Treaty partner (Beaglehole, 2007; R. Bedford et al., 2001)

British migrants continued to enjoy unrestricted entry to New Zealand until the 1970s. Australian citizens have always enjoyed unrestricted entry, and there were some special arrangements for entry for Pacific Islanders and the Dutch. After the First World War restrictions were placed on 'unsuitable' migrants, such as Germans and people with certain political beliefs (Undesirable Immigrants Exclusion Act 1919). A select committee charged with finding ways to increase New Zealand's population produced a Population Report in 1946 which provided the principles that informed immigration regulations up until the 1970s, including the regulations that allowed for Gen1 and Gen1.5 to immigrate in the 1950s. The report outlined that immigrants would be needed to meet some specific labour and skill shortages, and that preference should be given to people of British heritage. However, if this was not sufficient to meet labour and skill shortages, New Zealand would consider migrants from

Scandinavia or Northern Europe (Beaglehole, 2007). The Gen1 men met the criteria for a specific labour and skill shortage in the booming pulp and paper industry, and they were considered to be sufficiently British-like so as to easily integrate to New Zealand society. In fact, they were considered so British-like that no specific migration or settlement assistance was provided in government policy for the Finns who came from the other side of the world and spoke no English. This illustrates how policy can both provide capital and reduce it.

There are currently two ways to become a New Zealand citizen; either being born in New Zealand (some conditions apply), or through a process of naturalisation / citizen by grant. The term 'naturalisation' was used up until 1977, and citizen by grant since 1977 (D Green, 2009). After the Second World War the process of naturalisation was that aliens seeking New Zealand citizenship needed to be of 'good character' and, particularly in the 1950s, not have any communist affiliations. Most of the Gen1 and Gen1.5 participants were not citizens at the date of interview but chose rather to have permanent resident status which gave them most of the rights of citizenship and, prior to 2003 when there was no dual-citizenship option available, enabled them to keep their Finnish passports.

4.1.3. Finnish Migration to New Zealand

While the numbers have been relatively small, there is a long history of Finnish contact with New Zealand dating back to 1769, possibly enticed by good climate, size of the country and employment opportunities. Skill and labour shortages in the post Second World War booming pulp and paper industry in New Zealand precipitated attempts to recruit skilled Finns. The New Zealand Government attempted to make arrangements with the Finnish Government for financially supported emigration of Finns to New Zealand, however, the Finnish Government had no reason to support such an emigration, preferring that its skilled labour force remained in Finland to support their post-war growth. By 1953 private companies had taken the place of the attempted Government scheme, and assisted Finnish pulp and paper mill workers to migrate. The assistance of these 'desirable' immigrants by private companies was supported by the Government policy described above, and this is how Gen1 and Gen1.5 were able to migrate to New Zealand in the 1950s.

The relationship between Finland and New Zealand stretches back to 1769-1770 when draughtsman Herman Dietrich Spöring sailed into Poverty Bay with Captain Cook on the Endeavour, making Spöring the first recorded Finn to set foot on New Zealand soil. In recognition of his services, Cook

named an island after him at Tologa Bay on the east coast, making him the first in the expedition to have an island named after him. The name has now been changed to Pourewa, however, when Koivukangas (1996) visited the locals in 1988 they still remembered the place as Spöring Island. There is evidence that Finns were among the whalers in 19th century New Zealand, and some may also have arrived via the merchant ships, but the numbers would have been small and the population relatively transient. There is also some evidence that a few dozen Finns were lured to the New Zealand goldfields from Australia in the 1860s. The first Finn to live permanently in New Zealand was recorded in the 1854 Naturalisation Records.

Prior to the 1871 census, Koivukangas (1996) estimated there were about 50 Finnish residents in New Zealand, and that they mostly hailed from traditional seafaring areas such as coastal and Western parts of Finland. Many of these early Finnish migrants settled in seaports and along with Auckland, Banks Peninsula and the port of Lyttleton became a gateway to New Zealand. Messages were sent back to Finland encouraging friends and family to join the early settlers, and some chain migration resulted, with many taking up farming. From there, Finns settled in a number of different places across New Zealand, including Stewart and Chatham Islands. According to census data, by 1921 there were 314 Finns in New Zealand, mostly aged between 16 and 30 years and most likely motivated to migrate in search of adventure and employment. Between the two world wars only a small number of Finns immigrated, due to a combination of entry restrictions and poor employment opportunities resulting from the economic depression. New Zealand may have been seen by many of these early settler Finns as an attractive alternative to Australia and North America due to climate, size and employment opportunities (Koivukangas, 1996, 2005).

A minor peak in Finnish immigration in 1941 resulted from the seizure of New Zealand's first ever prize of war: the Finnish Ship s/s Pamir. War had again commenced between Finland and Russia in June 1941, with Germany invading Russia through Finland. As a result, the British Government issued a notice that Finland was to be considered a territory under enemy occupation, and therefore Finnish ships were to be seized. Britain cabled New Zealand an instruction to seize the Pamir, which was docked in Wellington Harbour. During the war while their ship was seized, the Finns in the crew worked and lived in New Zealand. Some of them married local girls and around half a dozen of the Pamir crew settled permanently (Koivukangas, 1996).

After the Second World War, New Zealand experienced economic expansion and growth. Of future significance to the Finns, forestry products were added to the three traditional export giants of wool, meat and dairy. In order to meet the labour demands of an expanding economy the Government relaxed immigration laws. In July 1947 a policy of assisted, or sometimes free, passage for immigrants from the United Kingdom was reintroduced, and in 1950 the National Government liberalized immigration policy to encourage 'desirable' immigrants from the Netherlands, Austria, Denmark, the Federal Republic of Germany, and Switzerland. While no specific policy existed in support of Finnish immigration, a movement of employers with an interest in the Finnish forestry labour force began. Employers were keen to import Finnish expertise and labour, despite acknowledging that:

Certain difficulties may arise due to the fact that Finland was officially an 'enemy country' during the war, but I am sure that the position of Finland is sufficiently understood to overcome any difficulties in this connection (excerpt of a letter from Mr A Carter, representing the Dominion Federated Sawmiller's Association, July 21st, 1949 quoted in Koivukangas (1996, p. 171)).

The 'sufficient understanding' referred to Finland's fight for her homeland against an invading Russia, where it was recognized that Germany was less an ally and more a cobelligerent in this effort. Mr Carter's full letter of support was subsequently attached to a Memorandum dated August 23rd, 1949, by A R Entrican, Director of Forestry, for the Director, Department of Labour and Employment, Immigration Division, Wellington, describing the shortage of required forestry workers in New Zealand:

It is recognized that Finnish Forestry workers are among the most skilful in North Europe so that it was considered expedient that the three New Zealand representatives to the Third International Forestry Conference being held in Helsinki should ascertain the availability of Finnish workers and the attitude of the Finnish Government to any proposed scheme of emigration (Quoted in Koivukangas (1996, p. 171))

A delegation visited Helsinki in 1949 including: Mr T C Birch (State Forest Service), Mr A Carter (Dominion Federated Sawmiller's Association), and Mr Freedman (Timber Workers Union). Their recommendation to the New Zealand Government was to support the immigration of Finnish forestry workers. On October 10th, 1949, the Director of Employment stated that the issue had been forwarded to the Ministry of Immigration, with support from the Controller of Customs who advised that:

The few Finnish immigrants who have come to New Zealand have proved a good type of settlers, and I can see no objection to the acceptance in principle of the proposal that a substantial draft of Finnish timber workers should be selected for settlement here (quoted in Koivukangas (1996, p. 172))

It was further advised that entry to New Zealand should be negotiated on the same basis as the Dutch farm workers; that is, the Finnish Government should be asked to pay passage to New Zealand in exchange for jobs and entry. It was perceived by the New Zealand Government that there were unemployed Finnish forestry workers as a result of Russia's annexation of Karelia in the war, with the Finns in Karelia returning to Finnish territory rather than remaining under Russian rule. However, the Finnish Government was slow in responding to this request from New Zealand, no doubt with other more pressing issues to attend to after the Second World War. A response from Niilo Mannio, Secretary General, Ministry of Social Affairs for Finland came in 1950 and stated that:

The possibilities for emigration from Finland are extremely limited, but it must be admitted that there is some unemployment amongst the forestry workers in the North of the country. I have not been able to get fixed the final point of view of our authorities concerning emigration of these people to New Zealand, but formally these people are free to emigrate. A mass emigration is, however, not allowed without permission. (quoted in Koivukangas (1996, p. 173))

The final decision came in October 1950 when E Sohlberg, the Councillor of the Finnish Legation in London, sent a letter to J Brennan, the Chief Migration Officer at the New Zealand Government Office in London, informing him that due to the improving employment opportunities in Finland there was no support from his government to provide financial assistance for Finns to emigrate to New Zealand. Finland's view was that people were free to emigrate, but this would not be supported financially by the Finnish Government, and a mass organized emigration would be subject to agreement. New Zealand had mistakenly assumed that Finland would respond to the offer of jobs and entry to New Zealand in the same way the Dutch had, by paying for their emigrants' passage. However, Finland did not have the same population and unemployment pressures as the Netherlands, nor did they wish for their countrymen to leave Finland during their period of economic growth. By 1953, private companies had taken the place of the failed attempt at a government scheme by assisting Finnish paper mill workers to migrate. The assistance of 'desirable' immigrants by private companies was fully supported by the Government of the time (Koivukangas, 1996, 2005).

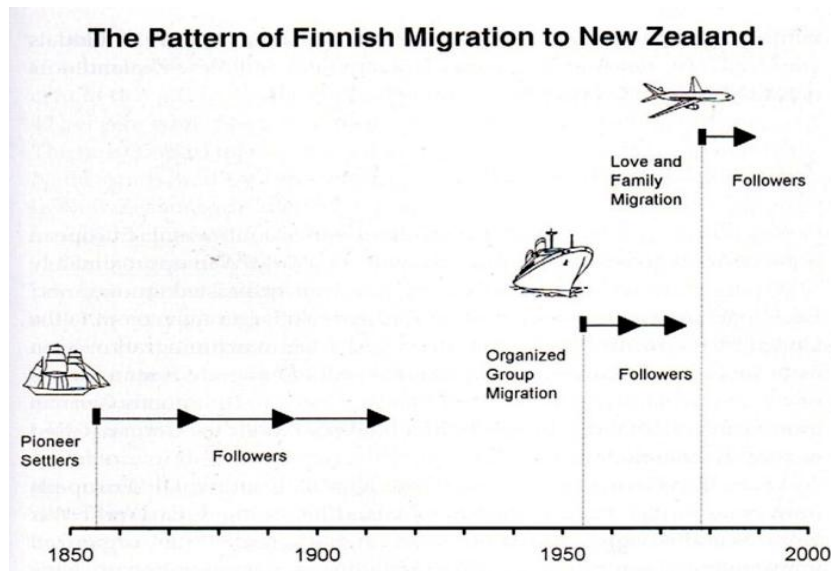


Figure 4 The Pattern of Finnish Migration to New Zealand (Koivukangas, 1996, p. 263)

4.1.4. Company Migrant Policy

Private company recruitment of Finns to New Zealand resulted in an influx of Finns to Tokoroa and Kawerau in the 1950s and 1960s. Koivukangas (1996, back cover) describes these Finns as: "...the pioneers of the New Zealand pulp and paper industry...". The relationship between timber and Finns goes back to the latter part of the 19th Century when pulp and paper mills began to be constructed in Finland in order to meet the Western European demand for timber and timber products (Solsten & Meditz, 1988). In the late 1940s, and early 1950s, a number of Finnish experts built and worked in mills in Whakatane and Tokoroa. The Tokoroa Finns wrote to friends and family in Finland encouraging them to come to New Zealand. Many did take up that encouragement, with some moving to Tokoroa, and also some to Kawerau (Koivukangas, 1996). The Tokoroa and Kawerau Finns accounted for the majority of the peak immigration years for Finns in New Zealand. In 1954, 61 Finns arrived, and in 1962, 40 Finns arrived. Most of the arrivals were aged between 20 and 40 years and many came with young children. In the second half of the 1960s there were between 150-200 Finns in Kawerau, the variation in numbers due to a mobile bachelor group working at the Tasman mill and living mostly in the purpose-built single men's camp (Koivukangas, 1996, 2005). Toivo Nurkka, one of the Finnish men recruited to the Tasman mill in Kawerau, documented aspects of the migration experience, commencing with the move of some Finnish mill colleagues to Tokoroa (see commentary and excerpts of Toivo's diary in Appendix Four).

In 1951 the National Government entered into a joint venture with the Fletcher Group to form the Tasman Pulp and Paper Company Limited, the largest company in New Zealand at that time. This company was to process the pine trees that were being felled in the Kaingaroa Forest, which had been planted primarily by depression labour in the 1930s, and were now reaching maturity. At the time, Kaingaroa was the largest manmade forest in the world, covering 160,000 hectares. Tasman began construction of a mill in Kawerau in 1953 which included a pulp and paper plant, sawmill, wood preparation plant, and a paper finishing plant. At the time of construction, it was the largest project ever undertaken in New Zealand. The paper machine, which was one of the three largest in the world, began production on October 29th 1955. By the end of the year it was meeting the paper demands of most New Zealand newspapers, and many in Australia. At its peak, the wages bill on site totalled forty thousand pounds per week, paid in cash each Tuesday ("Fletcher Challenge Archives: Tasman Pulp and Paper Company Limited," 2007; Koivukangas, 1996; Moore, 1991).

Moore (1991, p. 164) recalled that the bulk of the Tasman workforce:

...were to be New Zealanders, followed by Australians and the British (Welsh, Scots, Irish and English). Some of the other countries represented in the multinational workforce were Canada, USA, South Africa, France, Lithuania, Ukraine, Yugoslavia, Bulgaria, Holland, Russia, Malta, Romania, Poland, Italy, British Guiana, Germany and the Scandinavian countries – particularly Finland.

He further commented that: "Although the individual ethnic groups are not large, the nature of Kawerau has been influenced over the years by the different nationalities, in particular groups such as the Finnish community" (1991, p. 164). Helvi (Gen1) remembered that people in Kawerau were so friendly when they arrived and that:

As a whole, the Finnish people are very reserved - we noticed the difference coming to New Zealand. The New Zealanders were so open and so loving...but Kawerau particularly had that because everybody in Kawerau had come from somewhere – it was a new place. There were 18 different nationalities in Kawerau when we arrived.

James (1985, p. 12) described Kawerau as a: "...specially created town with a single industry and dominant company". As well as building the Mill, Fletcher Construction built the housing required to accommodate the millworkers to standard Ministry of Works plans. The building began in 1953 with plans for around 500 houses as well as public buildings. The housing project broke records for speed

of construction with 400 houses built in only 64 weeks. Moore (1991, p. 47) described Kawerau then as:

...a 'frontier town' in the true sense of the word – ditches for drains, water lines appeared then vanished. Roads and footpaths pushed further and further into the paddocks. Temporary wooden shops appeared, and a tent became a bar. Houses sprang up everywhere and dominating all was the building of the giant mill over the bridge to the north east.

By 1958, 789 state houses had been completed and the population was 3,500. Tasman had a policy of encouraging home ownership in the town and offered interest free housing loans to staff members who wanted to build their own house ("Fletcher Challenge Archives: Tasman Pulp and Paper Company Limited," 2007; The University of Auckland Business History Project: Fletchers Company Profile," 2007).

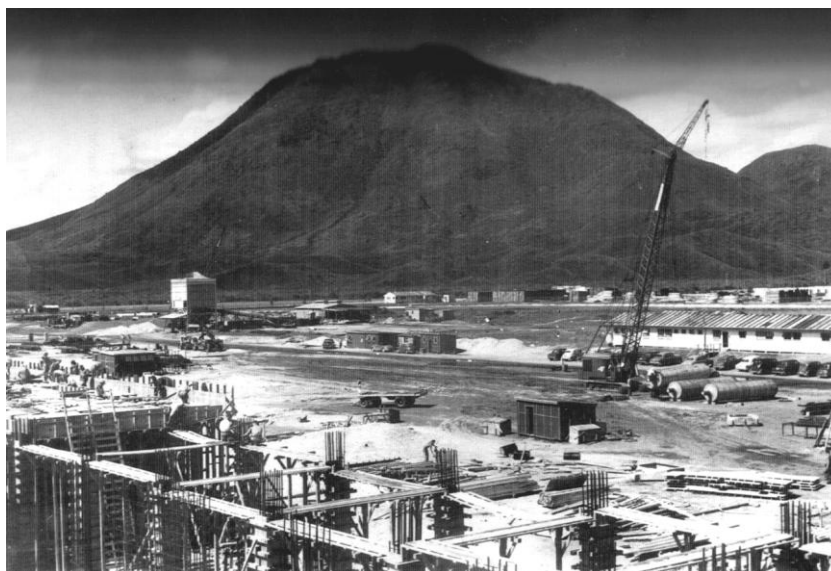


Figure 5 Tasman Under Construction in the Shadow of Mount Putauaki (Moore, 1991, p. 33)

Just as New Zealand Forest Products had done in Tokoroa, Tasman placed nationwide newspaper advertisements in Finland to recruit experienced staff for the Kawerau mill in 1954. Out of a total of 200 applicants, 17 men were selected for four year contracted posts at Tasman. Participants Inkeri, Niilo, Helvi, Rauno, Aino, Katie and Einari were part of this group. To be eligible the men had to be no older than 42 years and have pulp and paper experience, although an exception was made for Inkeri's husband who was 47 years old, because of his particular expertise. The youngest member of the group was only two weeks old at the time of departure from Helsinki. The recruits hailed mainly from towns in Finland with large mills such as Kemi and Oulu in the north of Finland, and the men

were made up of three engineers, two technicians and 12 tradesmen (Koivukangas, 1996). Twelve recruited families travelled to New Zealand in 1954 (including participants Inkeri, Rauno, Katie, Aino and Einari) and another five recruited families followed in December 1954 (including participants Niilo and Helvi). Chain migrants arrived under their own resources after this, including participants Sakari and Kaarina who migrated with their children Hilja and Rachel in 1959. Between 1962 and 1963 eleven additional recruits arrived with their families to work on the No.2 paper machine, including Mikko, Aila, Eino and Pentti who are also participants in this study.

Tasman company policy provided the Gen1 and 1.5 participants with significant support through migration and settlement, filling a void in government settlement policy and providing economic, social and cultural capital which had beneficial impacts through the generations. As revealed through the participants' narrative in the next chapter, Tasman provided well paid employment for the men, passage for some of the participants, English lessons, housing, furniture, a company doctor for the men and their families, land and materials to build a sauna, and arranged special classes for the children to quickly integrate them into mainstream classes. The buoyant economy allowed Tasman to provide this level of support to the migrants, and it was this micro-level policy that provided the greatest support to the migrants on settlement. This contrasts with studies of other Finns who migrated who found that difficulties with learning English presented barriers to employment which resulted in a lower standard of living (Baron, 2000; Koivukangas, 2004; Sintonen, 1993). Particularly relevant was the experience of the Melbourne post-war Finnish migrants who, while they had much in common with the experiences of the Kawerau Finns, had a different work and language experience. The Melbourne Finns paid their own passage to Australia and struggled to find jobs in their fields due to qualifications not being recognised, as well as their difficulties with learning English. Difficulties with the English language also made it hard for them to assimilate into Australian society (Baron, 2000).

4.2. Health and Social Policy

As well as the migration policies of the two countries influencing the experiences of participants in this study, health and social policies contributed economic, cultural and social capital that influenced the participants' patterns of thinking and acting with regards to health. When Gen1 and 1.5 left Finland they had already accrued significant capital, including health assets, and this was further enhanced through the New Zealand policy environment despite deteriorating economic conditions over time. This section explores these policies and investigates to what extent New Zealand policy accommodated

the health and social needs of the Finnish migrants invited to New Zealand under immigration policy, and if this policy has been responsive to the somewhat ‘invisible aliens’ over time.

4.2.1. Finnish Health and Social Policy

Domestic economic struggle marked the post-1944 war years in Finland with the challenges of rebuilding, war reparations (equivalent to US\$300 million in goods to be ‘paid’ to the Soviet Union), and the absorption of approximately 300,000 Finnish refugees from the ceded territories. Finland rose to these challenges, turning adversity into advantage and recovered quickly through rapid industrial expansion in the metal, shipbuilding and timber industries, boosting exports to beyond pre-war levels. The economy moved rapidly from primarily agrarian to industrialised in the 1950s (Encyclopædia Britannica Online; Visit Finland). By 1952 Finland’s growing economy enabled full payment of war reparations. Ironically, much of Finland’s future economic success resulted from a combination of the expansion and diversification required to meet war debt, as well as a secure post-war Soviet Union export market. The continued trade with the Soviet Union after war reparations had been paid also strengthened and stabilised the political relationship (Solsten & Meditz, 1988).

The post-war economic transformation precipitated a social transformation. The shift in the 1950s from an agrarian to an industrial economy resulted in the ‘great migration’ from the countryside to urban centres in search of employment opportunities. Post-war prosperity was well distributed with most sectors of society benefiting. An extensive system of social welfare programmes began to be developed in the 1950s by successive centrist coalition governments. Many supports were provided including income security, pension plans, maternity / paternity leave, health care, as well as other support services such as child care and maintenance allowances, family counselling and subsidised housing (Solsten & Meditz, 1988). Solsten and Meditz (1988, p. 25) commented that: “The general effect of these measures has been to raise the standard of living of the average Finn and to remove the sources of discontent caused by material want”.

When Gen1 and 1.5 emigrated between 1954 and 1959 the welfare system in Finland was still in its infancy; they would not have had the benefit of many of the future developments such as an improved national pension plan (1957), unemployment aid (1959), and a health insurance plan (1963). Public hospital care was generally free, and the insurance scheme compensated other medical costs outside of the hospital system. Compared to their Nordic neighbours, Finland was late in developing their welfare

system and it would take until the 1980s before the system was considered to be on a par with Sweden, Norway and Denmark. In 1950, expenditure on the welfare system amounted to approximately 7% of gross domestic product; by the 1980s this had risen to approximately 24% (Solsten & Meditz, 1988).

Since the late 19th century, and particularly following Finland's achievement of independence in 1917, the health of the country had been viewed as part of Finland's nation-building activity and had focussed almost singularly on suppressing acute epidemics, eradicating tuberculosis, reducing the infant mortality rate, and the development of hygienic thinking. The Finnish health system in the 1950s was based on hygiene and population policy, and was considered successful by world standards. Mortality rates had declined significantly over the first half of the 20th century; contagious diseases were under control, and tuberculosis was on the decline. Smallpox and pneumonia had ceased to be serious problems, and the vaccination law passed in 1952 contributed positively to a reduction in communicable diseases. The only increases in mortality rates Finland had experienced in the first half of the 20th Century were during the 1918 civil war, and the Second World War in the early 1940s. There had been a notable focus on the health of mothers and babies, and improvements in infant mortality rates were a source of national pride. Hospitals began to be constructed in earnest in the 1950s in order to bring the ratio of beds to population up to international standards (Global Health Facts; Leppo & Puro, 1972; Solsten & Meditz, 1988; Vuorenkoski, 2008).

One of the issues Finland would face in the future was declining population health. Along with other industrialised societies, including New Zealand, the hygienic thinking that had proved successful in Finland up until the 1960s was not adequate to address the emergence of chronic and personal health conditions, notably coronary disease which was linked to dietary habits. For most of the 20th century Finns had preferred to raise animals rather than plants for consumption, due to the climate and soil being less suitable for plant production and more suitable for growing forests and raising animals. As a result, a national diet rich in fats was viewed as the cause of the prevalence of coronary disease (Solsten & Meditz, 1988).

A scheme exists where Finnish war veterans were provided with a paid trip each year by the Finnish Government to attend a health spa in Finland or Australia. While these trips were not available in the early years post migration, in later years this policy contributed to the economic, social and cultural capital of the participants who took advantage of the offer. For example, my grandparents have

enjoyed many paid trips to Finland over the years, enabling them to visit friends and family in Finland regularly, as well as receive medical screening and minor treatments at a spa resort. Both the spa resorts in Finland and Australia have Finnish doctors and health professionals on staff and are only attended by Finnish war veterans and their partners. For migrant Finns, this is an opportunity for health treatment by Finnish health professionals as well as a time to socialise with other Finns. My Mummu told me that being at the spa in Finland saved her life. While she was attending the spa she had a heart attack, and she credited the staff being close at hand to administer life-saving treatment with her survival.

4.2.2. New Zealand Health and Social policy

The wider policy and economic environment has shaped health policy in New Zealand. For the first 30 years in New Zealand until the 1980s the participants experienced a country that looked after its people from the ‘cradle to the grave’. The next 15 years were marked by revolutionary reform of the economic, social and health system. The following 10 years, shaped by the Mixed Member Proportional (MMP) environment, saw a return to evolutionary policy development. When the Gen1 and 1.5 Finns arrived in New Zealand from 1954, a conservative National Party was in power and the health of New Zealanders had been improving from the 1950s. Up until the late 1960s the strong economy afforded those living in New Zealand a high standard of living and a welfare safety net that was both ahead of, and the envy of, many other first-world countries. The foundations of the protectionist economy and welfare state developed by Michael Joseph Savage’s Labour Government in 1935 supported a booming post-war economy built on strong primary commodity exports such as wool, dairy and meat. However, there was some social unrest developing with Maori seeking greater recognition of the Treaty of Waitangi and Maori cultural issues (Dalley & McLean, 2005; King, 2003). Like other industrial nations including Finland, New Zealand experienced notable changes in health and health care over the last century. Quin (2009, p. 1) summarised that:

The leading causes of death have changed from infectious diseases such as cholera and smallpox to chronic conditions such as heart disease, cancer and strokes. The number of older people, who suffer most from these conditions, has steadily increased. The focus of health services shifted from community primary care and disease prevention to the modern hospital equipped with the latest medical technology aimed at curing the new diseases.

Savage's vision of 'applied Christianity', a free health system with services universally available to all, was partly realised in the 1938 Social Security Act which established the benefit and pension system, as well as a universal public health system (Quin, 2009). A completely nationalised health system was never realised however, due to private sector resistance, particularly by general practitioners. The legislation was underpinned by the belief that health care needs were finite; a belief that was to be challenged by rapid post-war advances in medical technology (Easton, 2002).

Health services developed as a dual system of public and private health care subsidised by a series of General Medical Service benefits established in 1941 (Quin, 2009). Policy, purchasing and provision of health services was the combined responsibility of the Department of Health¹⁷, established in 1900. Health services were delivered through a structure of 18 District Health Offices and 29 locally elected Hospital Boards. The dual public and private health system aimed to deliver both curative and preventative medicine, but had a focus on the cures that modern hospitals could provide from the rapid increases in medical science. In the 1950s public health activity such as immunisation, pasteurised milk and fluoridation of water was met with resistance from some sectors of society. Public health efforts were renewed in the 1960s, including the launch of the first anti-smoking campaign. In the 1950s migrant health policy was focussed on recent migrants who were perceived to pose a risk to New Zealanders by bringing diseases with them from overseas (Dow, 1995; Easton, 2002; Gauld, 2009; Quin, 2009).

The 1970s saw a period of social, political and economic change for New Zealand. The Waitangi Tribunal was set up in 1975 to assess Maori grievances and claims that there had been breaches of the Treaty of Waitangi. New Zealand's main trading partner, the United Kingdom, joined the European Community in 1973 which heralded the loss of a guaranteed market for primary products. The world experienced an oil crisis, with two oil shocks in the 1970s. Robert Muldoon's National Government tried to stem the economic slide with 'think big' energy and industrial projects and farm subsidies, but a triple cocktail of unstable oil prices, inflation and unemployment seemed unstoppable. Muldoon handed the incoming Labour Government an economic, constitutional and currency crisis (Dalley & McLean, 2005; King, 2003).

¹⁷ Renamed from the NZ Department of Public Health (1900), Department of Public Health, Hospitals and Charitable Institutions (1909), to Department of Health in the 1920 Health Act

Between the mid-1950s and 1970s a number of reviews of the health sector were commissioned in response to growing concerns around escalating expenditure and issues of health equity¹⁸. Expenditure on health had been steadily growing since 1938, particularly on hospital infrastructure, equipment, and the clinical staff required to deliver the cures made possible by modern medical science and technology. Waiting lists had begun to develop in the 1970s in response to a growing demand for elective surgery. New Zealanders were able to purchase some surgery privately, which was funded mostly through Government subsidised health insurance. For the participants working at Tasman, many had private insurance as part of their employment package and this contributed to their stores of capital. The voluntary social and health sector developed in the 1970s, and accident cover was provided by the Accident Compensation Commission (ACC) scheme which was introduced in 1974. ACC provided a ‘no fault’ accident insurance system which was to compensate people for loss of wages and any medical bills resulting from an accident and was intended to be self-funded from a range of levies. The beginnings of health consumerism also arose in the 1970s with community health groups forming as a result of dissatisfaction with various aspects of health services (Gauld, 2009; Quin, 2009).

Mounting external debt and a deteriorating economic situation precipitated a series of reforms from 1984 under successive governments that was to fundamentally shift New Zealand from a protected and highly regulated state to one of the most liberalised economies in the world. The most radical brand of macroeconomic reform and restructuring in New Zealand to date was substantially driven by the fourth Labour Government’s Finance Minister Roger Douglas. ‘Rogernomics’ was to cut to the core ideals of the protectionist and welfare state through radical liberalisation of the marketplace, privatisation, benefit cuts, and an end to all farm subsidies. Michael Joseph Savage’s vision of a government that looked after its people from the cradle to the grave was fast eroding – the country was told it simply could not afford it anymore. David Lange’s popular, and still existing at the time of writing, 1984 anti-nuclear legislation resulted in suspension from the Australia New Zealand United States (ANZUS) security alliance and a recession in 1987 battered the country, taking until the mid-2000s to see any real improvement in the economy (Dalley & McLean, 2005; King, 2003).

This wider policy and economic environment precipitated a series of radical reforms in health, and the New Zealand health system has the dubious honour of being the most restructured in the developed world. In addition to structural reform, the 1980s heralded decentralisation of the health system, a

18 The Barrowclough Committee 1953, The Department of Health Review 1969, The Royal Commission on Social Security 1972, A Health Service for New Zealand 1975

determined programme to reduce expenditure, a focus on health quality and equity, a change of focus from purely curative to preventative health services, and the move towards a market driven framework for health. The cost of a General Practitioner visit grew as the gap widened between government subsidies for primary care and inflation, resulting in higher co-payments. Access to primary care became based on ability to pay - by 1991 the cost per adult consultation had reached around \$31. Inevitably, people began to seek their primary care from the free public system (Easton, 2002; Gauld, 2009; Quin, 2009). Reforms, including significant funding cuts in health and welfare, continued under a new government in the 1990s and included the introduction of ‘user pays’ or charges for public hospital services in 1992 which was short-lived due to considerable public pressure and difficulties administering the system (Dalley & McLean, 2005; King, 2003).

In response to public pressure in 1993, a change of government from National saw spending on health and welfare increase slightly despite on-going economic challenges, but the structural reforms continued under the 1993 Health and Disability Service Act. A competitive quasi-market approach was meant to drive down the cost of health service provision and achieve macroeconomic efficiency by: capping budgets, paying hospitals by contracted volume and quality, allowing purchasers the option of purchasing from public or private sector service providers, and supporting greater integration of the private and public sectors. The 1990s also saw the first significant changes in primary care for decades with a move towards capitated funding and increased accountability. General Practitioners formed Independent Practitioner Associations to manage the contracting involved with this decentralisation. Despite successive structural adjustments, a range of age-old institutional problems with the New Zealand health sector persisted (Easton, 2002; Gauld, 2009; Quin, 2009).

The 1998 Health and Disability Services Amendment Act allowed the National-New Zealand First Coalition Government to again reform the health system from a ‘for-profit’ to a ‘business-like’ model characterised by a single ‘purchasing’ agency and a focus on living within a capped budget. This resulted in more explicit rationing of services including: a reduction in financially non-viable hospital beds, devolvement of services considered non-core from a hospital perspective such as mental health and midwifery, and a national booking system for elective surgery (Easton, 2002; Gauld, 2009; Quin, 2009). There has been widespread criticism of the health reforms as being politically and ideologically driven, with many questioning whether they resulted in any health or fiscal gains at all (Ashton, 2002; Easton, 2002; Gauld, 2009).

In 1999 Labour's Helen Clark became the first elected woman New Zealand Prime Minister and presided over coalition Governments during three consecutive terms. Under Clark, New Zealand pursued an 'independent foreign policy', some say at the expense of a free-trade agreement with the United States. Despite this, a sustained period of economic growth and low unemployment, coupled with Clark's abilities to successfully navigate coalition arrangements, resulted in long term investment in social, health and economic policies, an overall high level of political and economic stability, as well as the settlement of a number of historic Treaty grievances (Dalley & McLean, 2005; King, 2003). Labour campaigned on the promise of another restructure of the health system on the basis that the current system was too competitive, had insufficient community input and lacked accountability and efficiency. The promised reforms were to continue the evolutionary change. The 2000 New Zealand Public Health and Disability Act allowed the Labour-Alliance Coalition Government to deliver on the election promises, this time by forming the structure of 21 District Health Boards (DHBs) in 2001 to manage secondary, tertiary and public health services, and forming Primary Health Organisations (PHOs) in 2002 to manage primary care (a structure that is current at the time of writing). DHBs are charged with meeting the health and disability needs of their populations and are guided by a number of Ministry of Health Strategies, including the New Zealand Health Strategy and the New Zealand Disability Strategy (Gauld, 2009; Quin, 2009). DHBs are also charged with meeting the health needs of migrants. Currently, while there is some specific reference to generic migrant health at strategy level, the implementation focus is on recent migrants who are perceived to be either vulnerable or likely to pose a health risk to the New Zealand population (whether refugees/asylum seekers or voluntary migrants). In many ways, this focus has not changed since the 1800s.

A key change from the previous structure was the removal of the funder / provider split – DHBs were now responsible for planning, funding and providing services for their population. Non-government organisations (NGOs) emerged fully as providers operating on a not-for-profit basis and were funded by DHBs to deliver health and disability support services. PHOs were to deliver primary care, including preventative programmes, to their enrolled populations through a number of health services delivered by GPs, nurses and allied health professionals. Additional targeted funding based on the demographics of the enrolled population aimed to support specific programmes as well as reductions in co-payments for high-deprivation population groups. Governance of DHBs was to be delivered by mostly locally elected Boards, there was a shift in focus from hospital services to preventative / public health services, and national targets were set with a notable focus on reducing inequalities between ethnic groupings (Gauld, 2009; Quin, 2009).

After nine years of socially democratic Labour-led coalitions, the country voted for change. In November 2008 a centre-right National Party formed a minority coalition government with confidence and supply support from the Maori, ACT and United Future parties under the leadership of Prime Minister John Key. Primary products continue to be New Zealand's main exports, and while the welfare system is not as fat as it once was it still provides a safety net for those most in need. Like many other countries, at the time of writing, New Zealand is grappling with the global economic crises and the implications for affordability of the health and welfare systems. While there has been a squeeze on funding for health services, at the time of writing no major reforms or restructuring that would impact directly on users has been implemented.

4.2.3. Ethnicity and the Inequalities Agenda

From the mid-1950s to the 1970s a number of reviews of the health sector were commissioned in response to growing concerns around escalating expenditure and issues of health equity within different sectors of society¹⁹. Public health concerns with the health of the Maori population had been present since the 1840s with the development of specific programmes to improve Maori health such as vaccination campaigns. However, it was not until the 1960s that specific studies comparing Maori and Pakeha health status emerged, with particular attention on mortality rates and tuberculosis. The early 1970s saw a focus on the Pacific Islander population and their relatively high rates of tuberculosis, as well as continuing work on the disparities between Maori and Pakeha that were revealed by new health indicators. In the 1980s there was a focus on health equity, or how health policy could address the inequalities in health outcomes between ethnic groups, socio-economic and gender groups, and people living in different regions in New Zealand. As discussed in 4.1.2 above, by the 1990s the ethnic make-up of New Zealand was multicultural and the focus on migrant health issues had developed from screening for diseases migrants might bring with them to reporting on the disparities in health status by ethnicity, in particular between the three ethnic groups of Maori, European and Pacific Islander. In the 2000s, the group of 'Asian' emerged as an additional ethnic group of interest in terms of health issues (Abbott & Young, 2006; Dow, 1995).

The 2000 New Zealand Public Health and Disability Act set the strategic direction and goals for health and disability services in New Zealand including reducing disparities between population groups and DHBs were tasked with delivering this reduction. District Health Boards collect data on the demand

¹⁹ The Barrowclough Committee 1953, The Department of Health Review 1969, The Royal Commission on Social Security 1972, A Health Service for New Zealand 1975

and need for health services and this is presented using base socio-demographic and geographical data that describe the community. The socio-demographic dataset includes migration and ethnicity information collected from a number of sources, with the latest census being a primary source (Coster, 2000; Ministry of Health, 2000). A 2008 Ministry of Health report on progress implementing the New Zealand Health Strategy confirmed that the framework to report on the goal of reducing inequalities in health relies on ethnicity and deprivation level data. The report also concluded that: "...although there are limitations to our ability to produce ethnicity data, we are making concerted efforts to find ways of improving the collection of high-quality ethnicity data" (Ministry of Health & Minister of Health, 2008). Most outcome indicators are reported by the four ethnic groups of European/other, Maori, Pacific, and Asian. However, Callister et al (2007, p. 302) argued that there is considerable heterogeneity within these four ethnic groupings, commenting that:

...while most people classified as European have ancestral roots in England, Scotland or Ireland, a not insignificant number of people have migrated from a wide range of continental European and Nordic countries, as well as from many other parts of the world, or are their descendants.

Statistics New Zealand (2009a) explained that the: "...health sector uses the statistics to allocate funding²⁰, tailor programmes and monitor results across ethnic groups". The primary data collection method is the national census which is held every five years. A review of the Official Ethnicity Statistical Standard was underway in 2011 with calls for feedback on proposals to change the way in which ethnicity data is captured in the census. The rationale for the review is evolving ethnic identity and the increase in use of the 'New Zealander' category which is considered a measure of nationality rather than ethnicity. Statistics New Zealand (2009a) stated that:

In the past two decades, Statistics New Zealand has endeavoured to match the way we measure ethnicity in official statistics with the changing nature of ethnicity in our society and the way that the information is used. A persistent challenge has been accommodating people of European ancestry, whose ethnic identity has evolved with the increasing proportion of this population living in New Zealand for two or more generations...the most recent Census of Population and Dwellings in 2006 resulted in an unprecedented increase in the number of people who reported a 'New Zealander' ethnicity in the 'Other Ethnicity' category.

20 Under the population-based funding formula (PBFF) model (introduced on 1 July 2003) each District Health Board is allocated a certain share of vote health funding based on their share of the projected New Zealand population, weighted according to the national average cost of the services utilised by different demographic groups. In addition, a policy-based weighting for unmet need that recognises the different challenges faced in reducing disparities between population groups is provided <http://www.moh.govt.nz>.

Over 90% of that unprecedented increase came from people who had reported a ‘New Zealand European’ response in the previous census. Concerns with statistical consistency have been raised and Statistics New Zealand (2009a) note that the “‘European’ and ‘Other Ethnicity’ categories have now become inconsistent with previous censuses and other sources of ethnic statistics”. The option recommended by Statistics New Zealand (2009a) is to:

...include ‘New Zealander’ responses in the ‘European’ branch of the classification that is used to report the statistics. This would ensure that the statistics remain consistent over time, and would address the growing inconsistency between the ‘European’ and ‘Other Ethnicity’ categories in the census and other sources of ethnicity statistics (such as birth registrations).

Callister et al (2007, p. 303) asserted that: “Given the often-complex backgrounds of people in settler societies, self-identified ethnicity in response to official surveys is often not a straightforward process” and that: “...culturally specific paradigms do not always overlap with official definitions of ethnicity”. Zodgekar (1986) proposed that a good case could be made to collect data on the birthplaces of the parents and grandparents of New Zealand residents. This would allow for the descendants of immigrants to be identified and questions on topics such as socio-economic mobility, language retention and intermarriage could be explored. However, Zodgekar (1986) also revealed a major short-coming of applying birthplace data – place of birth may be entirely irrelevant to ethnic origin or affiliation. Callister et al (2007, p. 317) recommend that:

With the ethnic mix of New Zealand potentially becoming more heterogeneous, as suggested by the data on younger people, more sophisticated ways of conceptualising and analysing ethnicity data in relation to health disparities will be required...we suggest that as international migration continues, and as intermarriage becomes more frequent in most nations, there will be pressure to move from single group, race-based measures towards culturally-based, complex ethnicity based measures.

While the ethnicity data debate is underway, health policy and programmes are being planned, funded and implemented based on the 2006 census data which is based on a somewhat reductionist and stereotypical view of culture, in addition to relying on the largest category of ‘European/other’²¹ for comparison when there are concerns around technical and non-specificity of reporting – for example,

21 Census 2006 reports population percentages as: European 65%, New Zealander 11%, Maori 14%, Asian 9%, Pacific 7%, Middle Eastern/Latin American/African 1%. The new category that emerged of ‘New Zealander’ skewed the European result in 2006.

Australians are considered the same as Russians, Zimbabweans and Italians from an ethnicity-grouping perspective (Abbott & Young, 2006; Beaglehole, 2007; Statistics New Zealand, 2009a). Statistics New Zealand (2009a) reference the following characteristics to determine an ethnic grouping: a common proper name, one or more elements of a common culture such as religion, customs or language, a unique community of interests, feelings and actions, a shared sense of common origins or ancestry, and a common geographic origin. This definition is based on the concept of ‘cultural affiliation’ which allows people to choose their own cultural identity and aligns well with the anthropological view of what constitutes a minority or ethnic group²². The option, provided since 1916, to select more than one ethnic group has allowed for ‘hybrid’ groups to emerge, and the ethnicity data in the census does not sum to 100%. To put this in perspective however, around 90% of respondents in the 2006 census identified with only one ethnic group. Those who selected more than one group were mainly Maori and Pacific peoples. The 2006 census reports the ethnic grouping ‘Asian’ as making up 9% of the total population. The 2006 Asian Health Chart Book aims to “recognise the diversity that exists within the ‘Asian’ population, and so avoid the pitfall of averaging” (Abbott & Young, 2006). The 2006 census reports the ethnic grouping ‘European’ as making up 65% of the total population (some might argue 75% is more accurate if 90% of the ‘New Zealander’ response is added) (Statistics New Zealand, 2009b, 2009c). The European/Other category are referenced as the main comparative group for ethnicity-related measures of health inequality. This raises questions of importance to the participants in this study - does the homogenous grouping of an arguably culturally heterogeneous, or culturally undifferentiated, group provide sufficient statistical specificity to reliably shape public health policy? With this dataset can health and social policy in New Zealand recognise the unique needs of its ‘desirable aliens’?

4.3. Economic, Cultural and Social Capital in the Migration Experience

In this chapter policy was explored as an influencing factor on the participants’ dispositions to think, feel and act in the field of health in the context of migration. Government and company policy provided the participants with good sources of economic, cultural and social capital over time, giving them significant resources and power over generations. While capital was provided through government policy, the most tangible resources were provided at a micro level through Tasman company policy, which made up for the lack of government policy support for the ‘British-like’ participants in the early years of settlement. However, it raises a question about how the unique needs

²² That is, any group that define themselves by reference to claims of common descent, language, religion or race. (Barnard & Spencer, 1998)

of the aging participants might be met given the on-going lack of targeted policy support as a result of the homogenisation of European migrants in policy.

Economic capital was provided by Finnish migration policy which presented no barriers for citizens who wished to emigrate in search of post-war employment. New Zealand migration policy welcomed the migrants as 'desirable aliens' who could contribute specialist skills to the labour force and integrate easily into 'white' New Zealand society. While capital was provided through this legal right to immigrate and work, there was no accompanying migration assistance or settlement programme. At the time Gen1 and 1.5 migrated the approach was to screen immigrants for health risk factors on the assumption that they did not need any additional support being considered sufficiently 'British-like' to assimilate easily into the colonial ideal of New Zealand society – this approach has not changed significantly over time. Fortunately for the Kawerau Finns, Tasman policy provided significant support which allowed them to settle quickly into productive lives and build their capital base.

Economic capital, in terms of access to health assets, was also provided through Finnish and New Zealand health and social policy. When Gen1 and 1.5 left Finland they enjoyed free public hospital care, subsidised non-hospital care and the benefits of well-established hygiene and public health policy; but not cradle to the grave welfare. In later years, the war veterans among the group were able to access fully paid trips to health spas in Finland or New Zealand each year. When they arrived in New Zealand they enjoyed the benefits of a welfare system, free public hospital care, subsidised non-hospital health care, free access to a Tasman doctor, and public health policy all supported by a strong primary economy in the early years of settlement. Some years after settlement they were able to access the government accident compensation scheme as well as private healthcare subsidised for some by Tasman. Even though, over time, the declining economy reduced the levels of economic capital from both government and company policy through a series of reforms and policy changes, the participants retained relatively good levels of capital through their access to employment and healthcare and the associated command over financial and health assets that built up over time.

Cultural and social capital was provided by Finnish and New Zealand migrant policy, although like with economic capital, Tasman policy was more tangible in the lives of the participants. In Finland emigration was considered a norm, even though New Zealand was thought of as being very far away, whereas in New Zealand immigration was considered a norm by many, particularly in Kawerau which

was populated by many nationalities when the participants immigrated. The participants acquired a level of cultural competence and knowledge about the experience of migration through these government policies and resultant norms, and also through Tasman's recruitment and settlement policies which supported them to live successfully in a stimulating multicultural environment. Tasman's policy of 'selecting' a group of people for their skills and knowledge and supporting them (and chain/family migrants) in their settlement no doubt encouraged a sense of pride and community. Tasman policy encouraged them to develop new networks of influence and support to restore the social capital they had left behind in Finland. This contrasts with the experience of Melbourne post-war Finnish migrants who, while they had much in common with the Kawerau Finns, had a different work and language experience due to a lack of the micro-level capital provided to the Kawerau Finns by Tasman policy. The Melbourne Finns paid their own passage to Australia and struggled to find jobs in their field due to qualifications not being recognised as well as their difficulties with learning English. Difficulties with the English language also made it hard for them to assimilate into Australian society (Baron, 2000).

4.4. Summary

This chapter on policy illustrated the usefulness of Bourdieu's (1999) notion of capital, showing how policy (both micro and macro) can provide or reduce various capitals for migrants across generations. It also found that the participant group and their descendants are, in policy, a somewhat invisible white minority and have by and large been treated homogeneously in health policy and practice along with all others who appear 'British-like'. This is mostly as a result of the idea that white migrants would easily assimilate into the host society, and would therefore not need any special consideration in policy or practice. However, this was based on: "over simplistic culturalist explanations" (Mason, 2000, p. 93) that assumed all migrants who looked 'British-like' would think, feel and act 'British-like' within a short period of time in New Zealand. Given the current focus on eliminating health disparities based on a somewhat reductionist categorisation of ethnicity, this chapter raises a question about whether Gen1 and 1.5 in particular may suffer from the assumption that people in the heterogeneous European category do not require any specific health policy consideration, and that through this their capitals may be reduced. The next chapter explores the experience of being Finnish in New Zealand through the stories of participants, and reveals how narrative can provide a highly nuanced view of the experience of migration and the nature of capital across generations.

Chapter 5. Being Finnish in New Zealand

The previous chapter found that policy provided the participants with economic, cultural and social capital. Building on the discussion of the policy environments in Finland and New Zealand respectively, the experiences of the community across three generations are explored through the stories of participants in this chapter, revealing a textured view of how a group of people made sense of their shared migrant history, and how they used the various forms of capital available to them as they lived their lives. Through this, they created a new identity, and an embodied sense of belonging in the world. Their unique shared history reveals some collectively held patterns of thinking and acting, which are likely taken for granted by the group. This chapter illustrates the usefulness of both narrative and habitus as theoretical constructs for revealing how people give meaning to experience, and how generational patterns of thinking and acting are influenced by histories and ‘sedimented’ by past experiences. The chapter also achieved the study objectives by discovering the multigenerational migration experiences of the participants, and continues the thesis narrative through a rich multigenerational portrait.

5.1. Introducing the Participants

The tables below are provided to assist with reading this chapter. Where participants used their Finnish name, they were given a Finnish pseudonym. Where participants had or used an English name, they were given an English pseudonym. A brief history of Finnish migration to New Zealand, situating the participants’ place in that history is appended, for readers unfamiliar with Finland (see Appendix Five).

Table 1 Participant Numbers and Pseudonyms

Participants	Total	Male	Female	Pseudonyms (<i>Italics = Female</i>)
Gen1	7	3	4	Sakari, Niilo, Mikko, <i>Kaarina, Inkeri, Helvi, Aila</i>
Gen1.5	9	4	5	Rauno, Eino, Einari, Pentti, <i>Hilja, Katie, Aino, Rachel, Sandra</i>
Gen2	9	3	6	Carl, Jorma, Paul, <i>Fiona, Diane, Linda, Maire, Jaana, Mirja</i>
Total	25	10	14	
	100%	40%	60%	

Table 2 Participant Family Connections

Gen1	Gen1.5	Gen2
Sakari & Kaarina married	Hilja & Rachel children of Sakari and Kaarina	Fiona, daughter of Hilja
	Pentti, nephew of Kaarina	Diane & Paul, children of Pentti
	Eino, nephew of Kaarina	Linda, daughter of Eino
Niilo & Helvi married		
Mikko & Aila married		
Inkeri		
	Rauno & Katie married	
	Sandra, sister of Rauno	
	Aino	Carl, son of Aino
	Einari	Maire & Jorma, children of Einari
		Jaana & Mirja, sisters

5.2. Gen1

The seven Gen1 participants were Finnish-born adults who emigrated from Finland to Kawerau between 1954 and 1962, ostensibly ‘pulled’ by employment opportunities at Tasman. For those who chose to stay at “Uncle Tasman”, as the company was colloquially known, lifelong employment was available to them, until retirement. At the time of interview, they had lived long and predominantly healthy lives, and ranged in age from 72 to 86 years of age, giving them an average age of 78. All had spent more than two thirds of their lives or more living in New Zealand, and most (aside from Aila and Mikko who moved to the nearby Whakatane District) lived in Kawerau throughout. All were married to other Finns, including one participant who was widowed. All self-identified their ethnicity as Finnish, and their religion as Christian (1) or Lutheran (6), although the majority noted they were no

longer practising Lutherans. Of those no longer practising, many commented that despite this they still had a faith in God. All identified both parents as being Finnish.

Gen1 had an average of two children each and their educational achievement varied from: Kansa Koulu (compulsory Public School for first 8 years) (2), Oppi Koulu (Secondary School) (3), and Polytechnic / University level (2). All Gen1 were retired, but their most recent occupations included: Pulp and Paper Maker, Managers (3), Barmaid, Assistant, and Quality Controller. Gen1's educational achievements reflected their schooling in Finland, as there was very limited opportunity for further education once in Kawerau. Their occupations, in turn, reflected their level of educational achievement, work experience in Finland, and opportunities available in Kawerau. Many advanced to more senior positions within Tasman over the years. Women had noticeably less qualifications due to war in Finland interrupting their schooling, and then a lack of educational opportunities in Kawerau. Despite this challenge, many of the women found employment in Kawerau, both at Tasman and in the community, fuelled by a buoyant national economy in the early years, and by a reasonably stable local economy supported by Tasman throughout their working years. They also had a strong desire to work in paid employment, as they had done in Finland prior to migration.

All self-reported Finnish as their first language, and on a Likert scale of 1 to 5 (with 5 being fluent), reported total fluency in speaking, understanding and reading Finnish. Slightly lower fluency in English was reported for some participants, as shown in the graph below. The reporting of English fluency may have been higher during their working lives when they were conversing in English more on a daily basis, and had a higher level of confidence in their ability (their actual fluency may have been the same). From my observation, Gen1 tended to speak Finnish when at home with their spouses and family, if they spoke Finnish. The Finnish language of the migrants appeared to evolve differently to people living in Finland. In the early years 'Finglish' emerged, which was the way Gen1 amalgamated Finnish and English into new words which remain in generally accepted usage in the community. When Gen1 and 1.5 went back to visit Finland in later years they noticed how casual the language had become – even with their addition of 'Finglish' they were still speaking the more formal form of the language that was common in the 1950s when they emigrated.

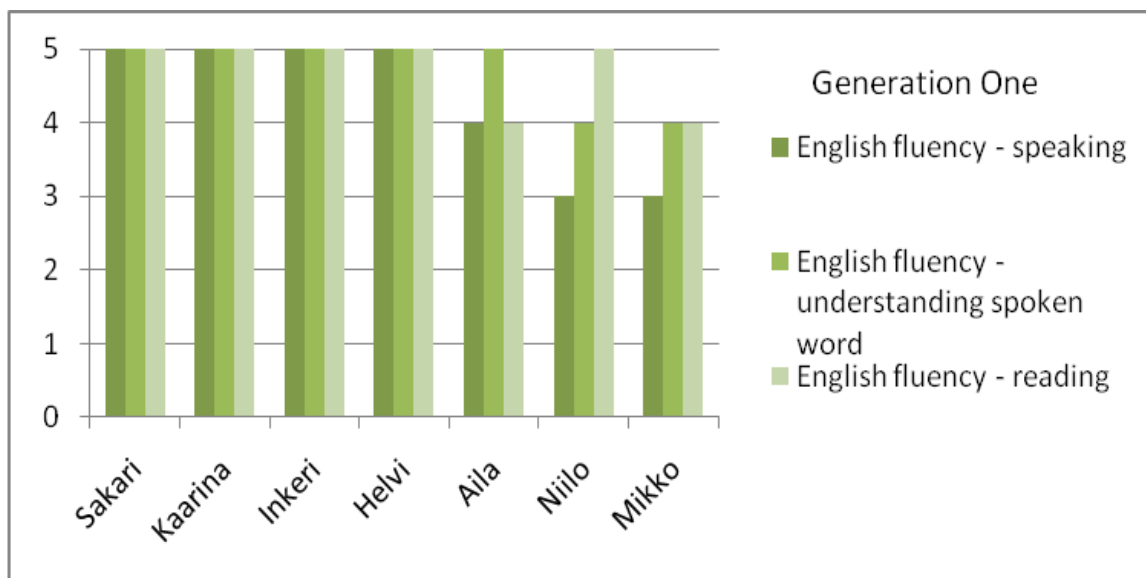


Figure 6 Gen1.5 Self-Reported Language Fluency

Most Gen1 remembered they had good jobs and lives in Finland. Aila recalled: “It was good life” and Niilo told me: “I had good job, and good house...” In the mills in Finland the house went with the job and the higher up in management your position, the nicer the house you got. This was mirrored in Kawerau. The management houses were larger and built at the top of town colloquially referred to as ‘Nob Hill’, a play on the word ‘snob’. In her study of Kawerau mill wives, James (1985, p. 18) found that a striking feature of Kawerau was “...the development of a local stratification system based on the industry’s occupational hierarchy” which mirrored the social stratification system based on employment in the Finland mills where a number of the participants had worked prior to emigrating, and this provided the Finns with cultural capital on migration.

The decision to emigrate was easy according to Gen1. They were perhaps influenced by supportive migration policy in both countries, and open to the ‘pull’ of adventure and employment and the ‘push’ of the memory of the hardships of war with the resultant political instability resulting from Finland’s position between the Communist East and Capitalist West (Baron, 2000, p. 22). Some of Gen1 described their decision to emigrate as fate. Inkeri recalled her husband’s experience with the Tasman recruiters:

When they opened [the door] he introduced himself and asked if there was a job for him in New Zealand in his area of specialty. When they had talked to him they realised, and they said they had forgotten to advertise for that job in that department, and they did not know that there was

that job in the new mill. So they accepted him there and then and they said, “oh we have got to find two more”. So that was like the fate.

Inkeri did think in the beginning that they would go back to Finland after her husband’s four year contract had ended. She said they even: “...bought small washing machine and small fridge, and we thought “oh four years’ time it be good to take back”.”

Niilo, who had a senior job in a large mill and a very comfortable life, had been to a woman who read tea cups who told him he would spend the biggest part of his life overseas. While Niilo said he didn’t really believe in old superstitions like reading tea cups, he did feel that the decision to move was like fate. Also, Tasman had offered him a bit more money than he was making in Finland, and he had liked the idea of an adventure. Like the other Finns that emigrated at that time, Niilo had a four year contract and his wife Helvi told me: “...the company was very very clever. Had it been a three year contract, everybody would have gone. That fourth year was the decisive one”. By the fourth year the children had settled into school with friends, and the migrants were involved in a very active Finnish community.

On October 11th 1954, the first recruited group of 12 Finnish men and their families flew from Helsinki to Glasgow on two chartered planes and then set sail on the Captain Cook. The Captain Cook carried 1,000 passengers bound for Australia and New Zealand. The first part of the journey across the Irish Sea was stormy and many of the women and children were seasick. Inkeri remembered how foreign the British food on the boat was for the Finns, and how the stormy seas resulted in many weeks of seasickness for some, but that despite these small hardships - because the war generation were used to hardships and hard work according to Gen1 - the trip was a grand adventure. The five and a half week voyage took the Finns to new and exotic places like the Panama Canal and Curacao. Wages commenced the day the Finns set foot on the plane in Helsinki, and as part of their contract the men were required to learn English. This was something Tasman had learnt from the experience of the Tokoroa Finns who initially struggled with the new language. Tasman provided a guide, translator, and English teacher to travel with the families from Helsinki to Kawerau. Miss Rowlands taught class every morning and afternoon, and while the men learnt English, the women took care of the children. Most of the Finns had not learnt any English at all previously because, at that time in Finland, English was not taught as part of the regular school curriculum like they do now. Inkeri remembered that: “Our company, Fletcher Challenge, really took care of us right from the beginning”. As described in the previous chapter, these company micro level policies provided significant capitals for the Finns,

particularly in the early years post migration. Unlike the other women, Inkeri did get to learn English because of having no children. Because of this, once they got to Kawerau she was also able to help with all the things needed to settle in and be a translator for many Finns that came later. She even ended up teaching some of the Gen2 children Finnish many years later, providing social capital to the wider community over many years as a result of Tasman's investment in an English teacher for the Finns.

On a cold, wet and windy Wellington day on November 18th 1954, 24 adults and 32 children were met at the port by a Tasman representative, Mr Roy Stoneham (who went on to become Mayor of Kawerau in 1965). Mr Stoneham gave the families a warm welcome and brought fresh milk for the children, which was happily received after five weeks of drinking orange-coloured water on the Captain Cook. The group boarded an overnight train to Frankton and then took two chartered buses to Kawerau.



Figure 7 The 12 Finnish Families on their way to Kawerau (Koivukangas, 1996, p. 204)

The trip, through the dense bush of the Rotoma Hills with native trees scratching at the buses, and slowly negotiating a winding single lane road with cliffs on the left and steep drops on the right, left the Finns wondering what sort of place they were coming to. Inkeri shivered as she recalled: “Well coming to Kawerau, coming down the Rotoma Hills, we thought we’ll never ever get back from here. We are so behind the God’s back that we never ever get back”. The bus driving on the left hand side of the road added to their unease, having been used to right hand driving in Finland. They did eventually emerge into a sunny but strange flatland of warm volcanic sandy soil, peppered with the accoutrements

of construction. When Niilo arrived later in December he recalled that: “Kawerau was nothing, full of hills and sand and sandflies. Just big mountain and nothing here, nothing. It was just eramaa eramaa – desert, eramaa.” They were serenely observed by the handsome mountain Putauaki, and the taste of sulphur hung in the back of their throats. Kawerau was bordered by native bush and pine forests on one side, and the fertile Rangitaiki Plains on the other. They settled into temporary accommodations at Tasman House and were welcomed by the locals who they remembered as friendly and helpful. The first weekend in Kawerau they were visited by Finns from Tokoroa and much fun was had by all. It did not take long for the Finns to settle into Tasman House, and the children quickly shed their formal clothes and enjoyed the Kiwi habit of wearing shorts and running around outside barefoot in the summer weather.

Within a few weeks the houses provided by Tasman were ready for the Finns to occupy and they left Tasman House. Tasman, taking a lesson from the experience of the Tokoroa Finns who were accommodated closely and tended to stick together, decided to ‘pepper pot’ the Finns throughout the town to assist their assimilation into the Kawerau community. This did work to a certain degree, but the Finns also quickly formed Finnish community structures which kept them in close relationship for many years and provided them with significant social and cultural capital. The men worked in various jobs at Tasman, as well as other jobs such as laying concrete around Tasman House, while the construction of the mill was completed. Tasman, again taking a lesson from the struggles of the Tokoroa Finns with language, continued the English lessons that were started on the Captain Cook for the men with half a day spent at Tasman and the other half in English class. From mid-December the women commenced English lessons in the evenings, also with Miss Rowlands. Some of the Kawerau Finns visited the Tokoroa Finns for their first Christmas in New Zealand, enjoying their first sauna since leaving Finland. Inkeri remembered fondly the good start the Finns got to life in Kawerau:

Tasman, Fletcher Company, had the Tasman House as a hotel and that’s where we were living first fortnight. So we been looked after right from the beginning²³. We were helped by this guide, the lady guide that we had with us, with everything like schools, and banking and the doctors and everything so we got good start to the life, yes.

By April the Finns noticed how unexpectedly cold it was in Kawerau, partly because they were expecting a warmer climate, and also because while they had been used to much colder outside temperatures in Finland, where the houses there well insulated and centrally heated. Frosts in the

23 Underlining indicates pronounced intonation

winter in Kawerau left the ground white and the wooden non-insulated houses with one open fire and single glazing did not keep the cold out, according to the Finns. They were grateful for the advice of the Tokoroa Finns who had sent letters telling them to pack their warm clothes.

After the first arrivals in 1954, other Finns started to arrive in Kawerau, mostly relatives and friends of the first group like Sakari, Kaarina, Hilja and Rachel. To facilitate employment and entry permission by immigration, Finns in Kawerau sought letters of support and guarantees of employment and accommodation from their Tasman bosses for their friends and relatives. The arrival of these chain migrants and a swelling Finnish community contributed even further social capital to the Finns. Even Finns who had no mill experience could get a job this way, and this is how my family came to migrate to New Zealand. My Mummu's brother Kaarlo Viitakangas, who was a Foreman at Tasman in 1958, requested letters of recommendation for his brother in law, my Mummu and Pappa, his brother, his other sister and later some friends. Kaarlo guaranteed work and accommodation for these immigrants and assisted them in their settlement. Koivukangas (1996, p. 214) recorded that: "In recognition of his work for good relations between New Zealand and Finland, Kaarlo Viitakangas was awarded the Knight First Class of the Lion of Finland in 1980." So, this is how my grandparents were able to come to New Zealand on the anniversary of Finland's Independence Day 6th December 1959, with their two daughters.

For these chain migrants, the company did not pay passage or housing, and for people like Sakari and Kaarina it was very expensive, about £1,040 for four people to fly one way which equalled approximately one year's good earnings in Finland. Sakari told me: "...that money should have bought a department flat or small house in Finland". He also said that he had looked at other places to migrate like Sweden, Canada or South Africa, but that the New Zealand climate tempted him, and also there were already some of Kaarina's family members living there. Australia was considered but had felt to Sakari "so large – so mighty" and because he had been "...born in island, which means water / sea is part of my life, someday New Zealand island country won that one." Sakari remembered it was an easy decision to migrate, he said all he needed to do was: "just pack your bag and move on." Kaarina told me they had tried to encourage other family members to join them in New Zealand, and some did, but that mostly: "...it was something they were not brave enough to do because they were so far away, and before we came to New Zealand we did not even know where the New Zealand was and it was hard to find on the map...". Sakari and Kaarina knew that if they did not like New Zealand they could

always go back to Finland, or move on to somewhere else, because as Sakari stated: "...facts were that we have enough financial resources to go back to Finland if we did not like New Zealand".

Sakari and his family came by aeroplane from Finland, landed at Whenuapai Airport, and then took a taxi all the way to Kawerau. Kaarina's family looked after them in the beginning until Sakari started work at Tasman, and they moved into a rented house. Sakari recalled that they arrived before Christmas and the green of the countryside was overpowering to their senses: "...culture shock was overwhelming smell – rotten veges, rotten fruit smell. I still occasionally feel that smell because we came from already winter Finland – air was clear there was no smell, no earthy smell."

The chain migrants did not have the benefit of the company English teacher and so had to learn English themselves. For the men, this meant on the job. Kaarina recalled that she "...learned English by trying to actually, actually at the beginning when the children went to school, I started to read those little school books and I think it was the children who tried to explain to me first what was this and what was that, specially my older child". Both Sakari and Kaarina remembered how they enjoyed the warm summer weather and the easy going and safe life they had in Kawerau, where they could leave their doors unlocked and everybody had a job. They also noticed how much more informal and laid back working life was. Sakari recalled:

Everyone was full employed. Finland that time was 5-6% unemployment. But then on the working place this easy going was negative because people...have a feeling that they go there have a good time and have a talk and just get a good pay packet, not to do much...Finland always been imperative that every individual has to carry his pack, otherwise out you go. Some other positive things were people were very friendly, and when I started to work at Tasman I couldn't get over how different it was here for a worker because the big bosses came and they were talking to you, calling you by your first name, which was unheard in Finland.

Eleven additional Finnish families arrived between 1962 and 1963. Mikko, Aila and their children, as well as Eino and Pentti were part of this group. This recruitment was to staff the No. 2 Paper Machine which started up on December 15th 1962. The passage and housing were paid by Tasman in return for three year employment contracts. This group did not come by ship, but flew from Helsinki to New Zealand via San Francisco and Honolulu instead. By this time, Kawerau had grown to a population of 5,000. One of the Finns from the first group, Mrs Seija Saikkonen, taught this second group English.

Most of this group, but not all, ended up leaving New Zealand after their contract term expired and Koivukangas (1996, p. 212) proposed that: "...a reason may be that these young people came to New Zealand for experience and to further their career and training". Helvi, however, would say that the fourth year would have been the decisive one. Another factor could have been the rapid recovery of the post-war Finnish economy, making a return to Finland an attractive proposition.

By the time the first Finns arrived, Kawerau had evolved from a frontier town, but was still far from civilized to the eyes of the cosmopolitan Finns. Inkeri recalled:

And then coming to Kawerau, because there was no town, there was only about, I would say, 100 houses ready, or maybe 150, and the town was full of sand hills and hundreds of construction men, and then we were told that 101 is your house, and 98 is the road you are in! So there was no town as such.

Their travel around New Zealand was reasonably limited in the early years, and so most would not have been exposed to the other more cosmopolitan aspects of New Zealand life that existed at that time (S Eldred-Grigg, 1984; S Eldred-Grigg, 1990; Hatch, 1994).

However, the Finns quickly adapted to this "created community" (James, 1979), building a Lutheran Church, a sauna and setting up a Finnish Club to organize sporting and cultural activities (Te Ara, 2008). Migrating Finns have a history of similar settlement activity, from the 'Finntowns' of the early 20th Century in America (Koivukangas, 2004) to the saunas, churches, Finnish clubs and societies in Canada in the 1920s (Sintonen, 1993), and in post-war Australia (Baron, 2000) which, like in Kawerau, were particularly strong in the early years of settlement.

Of the early days, Inkeri recalled New Zealand felt about 30 years behind Finland, and the influence of British style and traditions was strong. Kaarina remembered:

When we first arrived here we couldn't find the food from the shops that we were used to eating in Finland. Like all the Finns are big coffee drinkers, and we couldn't even find coffee at the shops. They did not even know anything about coffee, it was just tea tea tea. Tea trolleys going around. But also the shops. The clothes they had at the shops, like women's clothing, was like what we had before the war in Finland, very very old fashioned for our eyes. And we came here and we had European style, jackets and everything.

The Finns had to adapt to different food availability. Koivukangas (1996, p. 227) reported that the: "...shortage of sugar cubes was a hardship experienced" by some families. In Finland, serving sugar cubes with good Finnish coffee and pulla was an anchor of hospitality, but in New Zealand sugar cubes were given to horses. I remember a story that one of the Finnish women who spoke no English had to make 'oink oink' noises and slap her rump to get the details of the meat order over to the mobile butcher, to the great amusement of the Finnish ladies – and no doubt to the bemusement of the butcher. Another story I was told is how horrified the Finns were that bread would be sold with no paper wrapping. How uncouth this frontier town must have seemed in the early years! Sakari remembered the difference in alcohol availability; in Finland alcohol was strictly controlled but in New Zealand: "...it was free...for many one it was overwhelming temptation". All the Finns remembered a good standard of living in the early years in Kawerau, where the daily needs of life were plentiful and readily available, even if the special items were not. Helvi recalled:

Oh it was lovely...the difference was that the standard of living between New Zealand and Finland...it was a huge difference and it was so much easier money-wise to live here definitely, I think my husband's wages doubled or something.

The Finns quickly made friends in Kawerau with all nationalities, including Maori. Helvi remembered it was exciting to meet Maori people because she had not ever seen brown people before in Finland. Koivukangas (1996, p. 210) commented that: "...when the Finns became friends with local Maori it was said by some Maori residents of Kawerau that the Finns were well off. 'You guys had your trip paid for and you came by boat. We had to paddle over.'" When Maori came to speak to the Finnish Club, the similarities between the Maori and Finnish languages was noted. Vowel sounds are similar and there are a number of similar words, but with different meanings. One of the Gen2 participants had spoken with one of the local kaumatua before our interview who told him that while the Finns were pakeha, they were clearly not British, and they had a great affinity with Maori who embraced them. Sakari remembered experiencing cultural shock from the race relations in New Zealand in the late 1950s. He reflected that from his memory no legal statues supported segregation after 1948, but that the reality of race relations in Kawerau in 1959 was that some segregation still existed:

Finns particularly have easiest possible, than many other nationalities, get on well with New Zealand native population. So because Finns never been on occupying country or controlling somebody...In the early years because there was like Anzac Day or some other day Maoris could not come in to public bar until after certain hours, they couldn't enter, people did not let them to go to certain hotels even they were with Pakehas. That was cultural shock.

However, not all the Finns were as accepting of Maori, and some brought with them the monocultural ideals of the Finland they had left. Some of the Gen1 participants told me “off the record” that one of the disagreements that festered in the Finnish Club stemmed from differing views about Maori.

While the men were busy working and taking English lessons, the women experienced more of a cultural adjustment. In Finland, they had been used to living in busy towns and cities with ready access to shops and public transport, and in comparison Kawerau was very isolated in the beginning. They had also been used to working; some had been working in shipyards and factories, particularly during the Second World War when the women worked while men fought, but also after. Opportunities to continue education in Kawerau were also significantly limited for the women, and they felt they would have had much more opportunity in Finland if they had stayed. Inkeri reflected:

I possibly would have carried on education to start with because that was one thing I really missed badly, and I felt like I was dealt roughly because of that...But I'm happy here, and I knew that we would not be going back and I'm happy with that decision. There is a place there in the cemetery for me.

James (1985, p. ii) commented that Kawerau had a: “...specifically masculine character on account of restricted employment opportunities and traditionally male occupations” and that women in the town were mainly involved in domesticity and: “...women tend to come to, and remain in, Kawerau because of their husbands' jobs, and their own employment ambitions are severely curtailed” (James, 1985, p. 16).

The Finns soon settled in and most of the first group who came on the Captain Cook stayed in New Zealand, mainly in Kawerau all their lives, with only four families returning to Finland. Koivukangas (1996, p. 230) reported that: “...in 1987 it was estimated that from about 150 Finns in Kawerau in the 1960s there were about 50 left, and most of the children of the Finnish settlers were married and still living in the area”.

Building the formal and informal structures of the Finnish Community assisted greatly in settlement. Soon after arrival a sauna was built by way of a ‘gentlemen’s agreement’ that Tasman would provide the materials and the Borough Council would provide the picturesque spot on the banks of the Tarawera River. A Sauna Club was formed on February 5th, 1955, and all 17 families joined along

with the three single men who came later. The Club was open to all nationalities and over the years membership grew to such an extent that it eventually had to be restricted. There were separate times for men and women to go to sauna, and it could be booked by families. Inkeri remembered that:

...we first built the sauna - that was a thing that we all built together. We wanted to build one and we did. Sauna was up after 2 years I think. There were women and men and everybody there carrying sand and carrying planks and bricks...the District Council...gave us the reserved land to build it on. And the company had promised us the material to build the sauna. So that's one good thing that Fletcher really was good as an employer, they were fantastic...

Some of my fondest memories of Christmas Eve at my Mummu and Pappa's were the ruddy faced men of the family returning from sauna, ready to start the evening's festivities. I remember my Dad and then my husband being quite chuffed to be asked to attend sauna with my Pappa and the other Finns; it was almost a right of passage or acceptance. Subsequently, a number of Finns built saunas in their own homes or backyards, and eventually the Sauna Club disbanded and the communal sauna was dismantled.



Figure 8 Men and Women Building the sauna in Kawerau in 1955 (Koivukangas, 1996, p. 215)



Figure 9 Finns and a Local Policeman in the Sauna in the 1960s (Koivukangas, 1996, p. 216)

Many Finns had been members of organizations in Finland, and so the idea of organizing groups and events was familiar. Prior to the official Kawerau Finnish Club being established on June 5th 1961, various events were organized by the self-named Kawerau Finnish Community. These included fundraisers for the church and school. A social event to fundraise for the school was a huge success, attracting 500 people and raising £160. Finnish baking and handcrafts were guaranteed to sell at stalls, and the social events were always popular. Inkeri recalled that there was a real Finnish community in the early days, organized around the strong Finnish Club. She remembered that: “We organised it properly. We had meetings and we had committee selected and there were really a lot of cultural things that we carried on.” There were also lots of wonderful parties which the Finnish women baked for, and they danced and had a Finnish band. She remembered that lots of people came to the parties which were very popular, and they fundraised from that. Koivukangas (1996) recorded that the aims of the Finnish Club were to: maintain Finnish culture and habits (especially for the future generations), promote the social and other activities of members, help the Finns to adjust to New Zealand, and keep contacts with the old home country, and with other Finns in Australia and New Zealand.

The Club was very active, particularly in the early years, and included: monthly club nights where guest speakers were invited from a variety of sources including education, Maori and local government; baking exhibitions; and celebration of key events on the Finnish cultural calendar including Finnish Independence Day, Christmas, New Year’s Eve, Easter, Midsummer Eve and other celebrations. Celebrations were well attended by the wider Kawerau community and included performance of Finnish dances and songs in national costume with Finnish food served. A Finnish band was formed

and was a very popular act at local dances. Hobby clubs were very actively supported and included: English, music / choir, ball games, sewing circle, play circle, handicraft circle for girls, chess club for boys, fishing club, folk dance group, library, gymnastic club, a committee to arrange festivals and a camping circle. The Finnish Club sponsored a predominantly Finnish basketball team in 1962 which had many successes both locally and nationally. The various clubs also contributed to the wider community, with such activities as singing for the local rest home, and representation on other local clubs such as Red Cross and Rotary. The Club had a number of official visitors including the Consul for Finland, and the Charge d'Affairs for Finland.

By the late 1960s membership began to dwindle and some personal conflicts between remaining members crept in. In 1970 a decision was taken to allow those who were not Finns but were married to Finns or children of Finnish descent to join. By 1973 the membership had fallen to 39 from the peak of 56 in earlier years. Although the Club continued to be active, by 1978 the minutes had changed from Finnish to English in recognition of a growing number of non-Finnish speaking members. At a Special Meeting held on March 5th 1984 a unanimous decision to close the Club was passed, with all remaining monies to be donated to the Lutheran Church (Koivukangas, 1996). A number of Gen1 and 1.5 participants reflected that the Finnish Club had served the community well for 20 years. This pattern of strength in the early years following migration, followed by the eventual demise of the Finnish Club, was similar to the experience of other post-war Finnish migrants in Tokoroa and Melbourne (Baron, 2000; Koivukangas, 1996)

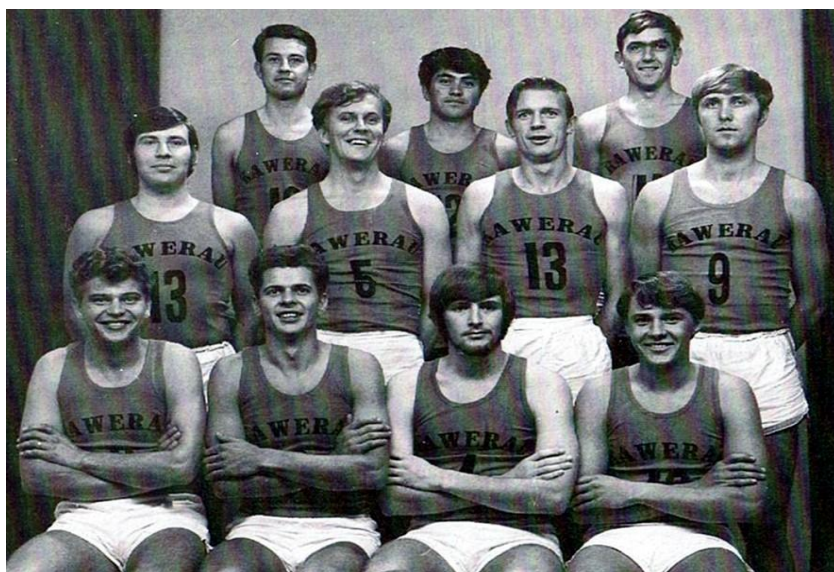


Figure 10 The Kawerau Representative Basketball Team 1969 (Koivukangas, 1996, p. 226)



Figure 11 The Kawerau Finnish Ladies' Singing Group (Koivukangas, 1996, p. 225)

A number of the Scandinavian engineers and technicians that built Tasman in the 1950s were Lutherans. This number continued to grow from 1954 as more Finns arrived in Kawerau with a desire to continue their Lutheran Church traditions. In the early years, contact was made with Lutheran pastors in Hamilton, Australia and the United States of America and there were a number of visits and services held at which children were confirmed and baptized. The number of Lutherans grew again in the 1960s when Finns arrived to staff the No. 2 paper machine, and the Lutheran Church began the process of establishing a local church in Kawerau. One of the visiting pastors from the United States established a Sunday School early in 1958, and after he left this was continued by Mrs Aune Karjalainen. With the support of Reverend Steicke, the predominantly Finnish Lutherans in Kawerau decided to build a church on July 2nd, 1963. The project was financed by the New Zealand Lutheran Layman's League through a loan of £3,300. Fundraising events were held and, where possible, the work was completed by congregation members. For example, Jorma Paavonperä built the altar, pulpit and other parts of the interior. The official opening was held on October 17th, 1964 by Reverend Steicke. Inkeri recalled:

...we decided to build the church and start the Sunday School. That was one thing that was missing in New Zealand, there was no religious teachings on any schools at all and that was one thing that many of the parents...we felt that the children will not know any proper meaning of Christmas and Easter and even the various things that we celebrate during the church year.



Figure 12 The Lutheran Church in Kawerau, Opening Day October 17-18, 1964 (Koivukangas, 1996, p. 221)

While the strong Finnish Community structures helped with settlement, Gen1 recalled different feelings about homesickness in the early years. Inkeri found fulfilment in her decision to immigrate:

...no, I been never homesick, never. No, when we said goodbye when we left for New Zealand, my Mum said to me – “visit my grave when you come back”. They did not think we’d come back. And I said to Mum after ten years in this country: “Mum, I come to see you, not in your grave but you, and another 10 years’ time I come to see you again”. And I did. I did not feel homesick because I knew that there was the meaning for me to be here in New Zealand and I got my life, what’s the right word, really fulfilled being here...

Sakari reflected:

Some of us say that naturally beginning to come here, so called ‘homesickness’ back to old country was hindering many years. But it was probably for the location - you born there and it is home [Sakari]

For Helvi, her first years were dominated by her yearning for home, so powerful as to affect her physical health:

In the first one or two years I was ready to pack. You should have seen the hives I got, I was covered in hives and I was told it was just my nerves because I couldn’t take it...in that first two years I don’t know it was – I was probably homesick in the first place. Homesick for the country. Never people there, I was never – I had no ties really left anymore. But then my husband’s

family had become my family so – home, the family. The lollies and the food and the mammi²⁴ and Christmas food and things like that. Just the country – oh the country. I started thinking New Zealand was home in the fourth year. And not 100% yet but...if you take the balance I was more wanted more to stay here than to go back. Also the children were settled and we did not want to uproot the children again [Helvi].

Mikko reported hardship in relation to work that made him homesick:

...this workplace was not very good beginning because nobody knew anything and they were long days, very often 16 hours per day. It was about three, four years before I got first holiday. It was really hard, beginning.

But after a while, everyone's homesickness got less and less and eventually disappeared. Narrative revealed this as Sakari put it poetically:

Nice way we say
“if you lose a patch of skin it will grow up
it will grow back”
In 7 years' time our skin renewing all the time
and so hair

So time is clearly...
most emotional things and new location
slowly and absolutely
will fill empty place
And so-called homesickness will turn secondary
It goes past
You can pick it up anytime
but it has no emotional waves anymore so much

It probably still sensitive subject to talk about
but it can be
...switched off

24 Traditional Finnish Easter dessert made from rye flour.

When you get older
and if you have a family
family contact – whanau – is taking first spot
your family number one
and everything else is secondary

but not impossible

Some of the Kawerau Finns travelled back to Finland for significant funerals, such as of a parent, while others did not return until Tasman paid for the trip at their 30 year anniversary. The war veterans among the group were provided with a paid trip each year by the Finnish Government to attend a health spa in Finland or Australia; these trips were not available in the early years. For many of the Kawerau Finns, it was emotional returning back to Finland for the first time after migrating. For most of the Finns, it would be many years before they returned to Finland and they found that places were no longer the same. Their greatest happiness was in seeing family and friends they had left behind, as well as eating Finnish food and visiting familiar places. The Finns had also changed; they had taken on some of the Kiwi traits of informality and seemed, in comparison to those in Finland, somehow more outgoing. For all of them the trip felt like a wonderful visit, but it was not home anymore. Mikko reflected on his first trip back that:

It was bit emotional. Yeah. But then some places when you went there, it was everything changing and changing and changing...it's not the same, but then you find something old one and yeah yeah that stays the same and then you start remembering...

Niilo remembered feeling very patriotic on his first trip back, waiting for two or three extra days in London just so he could fly back to Finland on Finn Air. When he got to his old home town, he said he: "...recognised, but I did not feel like home." All the Finns who went back noticed that things had changed in Finland; they had also changed. One thing in particular they noticed was that the grammar and language was not as formal, but some things were:

...surviving unbelievably same way – variation naturally with some influence from wider world. But, stubbornly they still remain same thing – special dishes, Easter time, Christmas time, even this particular Midsummer festival – they haven't changed their habits. It's sometimes a little shock that they still doing the old ways [Sakari].

Helvi told me she had been in Kawerau from 1954 to 1971 before she went back to Finland and that: “...by ’71 I wasn’t homesick anymore and I did not want to move back because I loved whatever was there but I couldn’t wait to get back [to New Zealand]. The main thing was my children, because they had all the chances here”.

Table 3 Gen1 Conception of Identity

Gen1	Years Lived in Finland	Identity Conception
Sakari	34	I am always Finn
Kaarina	30	Of course I am a Finn
Inkeri	28	All those things that matter in life make me a Finn
Niilo	33	I am Finn, never change that, never
Helvi	25	I am still a Finn, deep inside I am still a Finn
Mikko	19.5	I am always a Finn...that’s in my blood and in my soul
Aila	23	I am mostly Finn and nobody can say against this

Narrative revealed how all Gen1 participants conceived of themselves as Finns. Gen1 were Finns in their hearts and souls, and the language, history and traditions were important to them. Like the following generations, identity was constructed across difference, and conceived in terms of the boundaries that distinguish ‘us’ from ‘them’ (Baron, 2000, p. 27). Sakari told me: “Overwhelming is I had born Finn, language, and visiting there means I am always Finn”. Helvi reflected: “I’m still a Finn, deep inside I’m still a Finn...when a Finnish person leaves her or his country, goes to another country, he or she always and always leaves a part of herself in there and there is nothing you do about it – you are part of it”. Aila said: “I don’t mind if somebody tells me ‘oh you are New Zealander because you are here been so long’ – of course I’m like New Zealander too but I’m mostly Finn and nobody can say against this”. Mikko stated: “I’m always a Finn...that’s in my blood and in my soul. I’m still Finnish. I’m not Kiwi. Yeah I know it, I am Finn. For some reason I feel like Finn, oh yes. Never change that, never will change, never” and poetically reflected:

Might be because
because I born over there
why...
it’s like a plant
taking off the pot
uprooted and planted somewhere else
it might not survive better
...your roots stay where you born

Inkeri illustrated her Finnish identity with a story from her war experiences, again illustrating how narrative gives meaning to experience:

All those things that matter in life make me a Finn...I also happened to have O group blood...and every time there was a trainload of wounded soldiers coming to the railway stations in the early hours of the morning, I get the phone call from the hospital 'how long since you last given the blood', so I had to give my blood even to those wounded soldiers, so why would not I feel Finn?

With one exception, Gen1 did not consider giving up their Finnish passport and citizenship, preferring instead to have the status of permanent resident, even though since 2003 Finland has permitted dual citizenship. Up until 1977, becoming a citizen of New Zealand was called 'naturalisation' and since then it has been called 'citizen by grant' (David Green, 2007). Permanent residents, in contrast, are not citizens but have approval to live in New Zealand permanently (The Department of Internal Affairs). Most of Gen1 and 1.5 fell into this category which allowed them to reside permanently in New Zealand, as well as keep a Finnish passport and citizenship should they wish to.

When I asked Mikko if he would consider getting New Zealand citizenship or passport he said "No, never, never would be. Why? Finland is my country. I never change." Helvi reflected that for her: "It's giving up the Finnish rather than taking on the New Zealander" and this 'giving up' would likely have resulted in a loss of capital. Gen1 all loved Finland and had strong patriotic feelings. Helvi explained why she thought this was the case:

I tell you what it is with my age group, I think it was the war that made it so ultra patriotic...made us so patriotic for Finland. And we feel we owe this loyalty to Finland still, the way that what the country's gone through and all this, it's partly emotional but it's more than emotional. Really it's deep inside us.

However, many Gen1 also said they were 'New Zealanders in a way', because they had been here for so long, and this had been a good country in which to live and raise their families. Kaarina reflected:

I don't have any special thing that makes me think I'm New Zealander but because I've been here that long, longer than I never was in Finland. I think I am a New Zealander, I cannot say that I'm a Kiwi but I'm New Zealander. And it's been good for us, good for me, good for my husband and good for the family. So.

The notion of Finnish food and other traditions continued to be important to Gen1 (the symbolic nature of food is further explored in Chapter Six). Kaarina remembered the importance of Christmas rituals in particular, and that these had carried on in New Zealand. Kaarina reflected that one thing they still did in Finland was to: “go to the graveyard on Christmas Eve and...take the candles to the graves of the loved ones and burn them there” to remember that Jesus is the light of the world and so they like to keep the light there for the dead. She said that while she could not leave candles at the graveyard in New Zealand because of the fire risk, she and others still took flowers to the graves of loved ones at Christmas, and this was an important tradition they had adapted but continued in New Zealand. Traditionally, birthdays in Finland for adults were celebrated only on the ‘big birthdays’ like 40, 50, 60 but for children they were celebrated every year. Gen1 mostly celebrated all the birthdays here in the New Zealand tradition, but the ‘big birthdays’ were still special and there were often large celebrations with special gifts. Usually the women made a traditional cream and fruit filled Finnish birthday cake, and also prepared the table with traditional Finnish food and coffee for visitors. The Finnish tradition of celebrating one’s nimi paiva or name day (the day one’s name appears on the Finnish almanac²⁵) was not as celebrated by the Finns in New Zealand as it is in Finland.

None of Gen1 said they would consider a move back to Finland because of the cold climate, and also because of friends and family they would leave behind in New Zealand. Kaarina shook her head and physically shivered when she told me: “I don’t think I could survive in cold winters anymore. I must say that I did not like the cold winters, the long autumns when it was raining for weeks and weeks and weeks. Oh no, I was glad to be out of that.” Inkeri went and stayed in Finland for four months at one stage thinking of a possible move back but said: “When the first frost came that was it...I’ve climatised to New Zealand – climate alone up from the North it was too great, I couldn’t survive there.” Kaarina also said that she would not move back because of:

...the friends I have made, friends in New Zealand, New Zealand people, and then because the family is here...I have a feeling that I would be too old to move anymore, I think this is my home. For some of us home is there where the children are...for children, grandchildren, great-grandchildren.

Inkeri stated that: “...you cannot go to the same footsteps you left. In four years’ time even, your friends have made new friends and you haven’t got the same situation what it was when you left”. Aila agreed: “I don’t want to move back to Finland ever because you lost all your friends there. We have

²⁵ where all Finnish names acceptable to the Evangelical Lutheran Church are listed

still some people we know alright – they are not really our friends anymore, they haven't lived our life". Sakari did say that they now never wanted to move back to Finland, but at one stage they did consider it to be nearer to their eldest daughter, illustrating the importance of family to the Finns through the following narrative:

Except we did one thing, when our eldest daughter Hilja finish school and so she did go OE like people here, but our back-mind thought was, if she likes to stay in Scandinavia, Finland or Sweden, we are ready to go back. When she did not like and came back here, then that was that. Yeah, we had already place in Sweden just go there and just work.

Inkeri explained why she thought the Kawerau Finns did so well on the other side of the world through telling a story of her last trip up North before emigrating:

When you go further North, more North than Kemi, I went to Lapland before I came to New Zealand, and I travelled by train for over an hour, then the railway finished. Then I travelled by bus for 10 – 11 hours for bus, and then the road finished and there, even trees don't grow. This is so-called Lapland – Arctic Circle. And when the road finishes, the bus leaves you on the bottom, the road finishes by the huge big mountain – huge Ailigas Mountain, and there is a hotel/motel on the end there because that's where everybody has to stay. Except there is a Tenoyoki River who runs 110kms further North to the Northern most village of Finland and in the winter it's snow covered and ice, and the snow cat, or some kind of a snow mobile, it's a tractor sort of with the aero plane engine at the front, and that takes you the last 110kms. When you are left by the bus under that big mountain you know for the sure that if you were left there by yourself you couldn't survive. So, you need to be with them people that were in the bus, you would not survive there by yourself. So and that's when you sort of, that's how most of the Finnish families still live and still feel close knit yes. And you need to have a close knit to be surviving in the Arctic Circle.

Social and community support was important to Finnish immigrants in a number of countries. For example, Baron (2000) reported how Melbourne post-war Finnish migrants had much in common how the Kawerau Finns set up their community. They both set up informal cultural support structures such as the Finnish Society and Sauna Club, as well as the more formal medium of identity construction through the Lutheran Church, which were particularly important in the early years of settlement. Also like the Kawerau experience the Finnish Society split in time due primarily to personal strife between members based on some wanting to keep the Society totally Finnish and focussed on social activities,

and others wanting to expand to encompass the wider society. As in Kawerau, the Finnish volleyball team that grew from the Society developed into one of the top teams in the state (Baron, 2000). Neither the Kawerau or the Melbourne Finns had a significant impact on the culture, cuisine or politics of the receiving country and Baron (2000) posited that in Melbourne this was because they were a small community, lacked 'exotic appeal' and therefore were not of interest to the mainstream society and so did not attract a negative label that needed to be dispelled, and the organisations formed were apolitical and did not aim to influence public opinion. One difference for the Kawerau Finns was that they did have some 'exotic appeal' in the small Kawerau Community, and this contributed positively to the identity construction and sense of belonging for all three generations, as well as providing cultural and social capital. Both groups were considered desirable immigrants by the receiving countries as it was assumed that Nordic settlers would be similar in habits and complexion to the host population, and therefore it would be easy for them to assimilate (Baron, 2000).

The Melbourne Finns had a different work and language experience to the Kawerau Finns. They all paid their own passage to Australia and struggled to find jobs in their field due to qualifications not being recognised, as well as their difficulties with learning English. Difficulties with the English language also made it difficult for them to settle in Australian society. Most of the Finns interviewed by Baron (2000) were still speaking Finnish as their primary language 40 years after migrating. Although they encountered these difficulties, the main reasons the Melbourne Finns emigrated were the same as the Kawerau Finns on the surface - employment, warmer climate, and adventure. They were also encouraged to migrate by a desire to escape the political instability resulting from Finland's position between the Communist East and Capitalist West (Baron, 2000).

Like the Kawerau Finns, the Melbourne interviewees viewed their Finnishness as a "natural and inherent a quality of their hearts, or a mind-set acquired in birth and from mothers' milk" not simply membership of a Church or Society, or exclusion from wider society. Baron (2000) also proposed that identity was constructed across difference, both difference from the receiving and sending society. She found that the Melbourne Finns became 'hybrids', neither like Australians nor like the Finns they left behind. Like the Kawerau Finns they had developed their own version of the Finnish language, both more formal like the Finnish they had spoken in the 1950s, and including aspects of 'finglish' or hybrid slang developed between Finnish and English. They had also diminished their local dialects as they had become used to speaking Finnish with people from many parts of Finland in Australia. This new form of the Finnish language enforced their shared identity as migrant Finns. They also shared

experiences of their visits back to Finland, finding that while they enjoyed visiting friends and relatives, they no longer fitted into that society – things had changed since they left. They found the Finns to be formal and less worldly than they had become. They seemed to base their sense of Finnishness on their homeland as it was before they left in post-war times, as opposed to modern day Finland. Baron (2000) concluded that for the Melbourne Finns, being Finnish was not only about being from Finland, it was about the shared lived experience of being a migrant. Consequently, the second and third generation Finns in her study maintained their ethnicity as a source of pride and nostalgia, but had not incorporated Finnishness into their everyday lives.

5.3. Gen1.5

Gen1.5 were the children of Gen1 who were born in Finland and ranged in age from 55 to 69 years at the date of interview, with an average age of 62 years. Like their parents, most (aside from Rachel) had spent the majority of their lives living in New Zealand, and for most of that time living in or near the Bay of Plenty. As adults many had moved out of Kawerau, which had become less and less prosperous as “Uncle Tasman” had successively downsized in response to worsening economic and market conditions. Employment was also available to Gen1.5 in Kawerau, and consequently many spent their lives in the Bay of Plenty enjoying a good lifestyle close to family, with wages from “Uncle Tasman” that have consistently rated higher than the national average.

All Gen1.5 were married, but unlike Gen1 who had Finnish spouses, their spouses were from a variety of ethnicities identified as: Fries, Finnish (2), Maori, New Zealander (2), Israeli / New Zealander, Kiwi, and British. Marriage to non-Finns appeared to have an impact on whether or not Finnish traditions were kept by Gen1.5, and subsequently the strength of the traditions kept by Gen2. Where non-Finnish spouses were supportive, there appeared to be a greater level of Finnish practices in the household, particularly where the non-Finnish spouse was a woman. Ethnicity and gender of spouse also had an impact on the Finnish language. All Gen1.5 viewed the Finnish language as important and many regretted they did not take enough care of the Finnish language for themselves, in some cases and also for their children. They spoke of the Finnish language as something precious and delicate, that required looking after and caring for. Once they married non-Finnish partners, English became the primary language spoken in the home and so their children did not grow up speaking Finnish. Adding to this, the Finnish Dads were often absent from home life when the children were younger, as they were working shifts at Tasman. This in turn affected the language ability of the Gen2, as most were not brought up with Finnish spoken in the home. Even the Gen 1.5 Finnish couple did not speak Finnish in

the home, preferring English and only speaking Finnish (to varying degrees of fluency) with their Finnish parents. This was most likely in response to the government and Tasman policy of the time in encouraging assimilation. Another marker of the impact of assimilation policy was the choice made by a number of Gen1.5 to anglicise their names to make it easier for non-Finns to pronounce and spell. A number of Gen2 did the same, who also commented that they noticed that people could not pronounce their names when they were growing up which was irksome to some. However, as adults, they became very proud of their different names in the era of multiculturalism.

There was a slight shift between generations with regards to ethnicity, religion, and language. This group identified their own ethnicity as either Finnish (7) or European (2), and their religion as Lutheran (7), Messianic Jewish (1), and as no religion. Again, like Gen1, of the participants that commented they are no longer practising Lutherans they noted they still had a faith in God. Gen1.5 self-reported Finnish (3), English (3) and Finnish & English (3) as their first language(s). All participants reported total fluency in English across the domains, except for one who rated himself as 4 in speaking fluency. Most reported less fluency in Finnish, as shown below. This evidences a change from Gen1 who reported high Finnish fluency, and slightly less fluency in English.

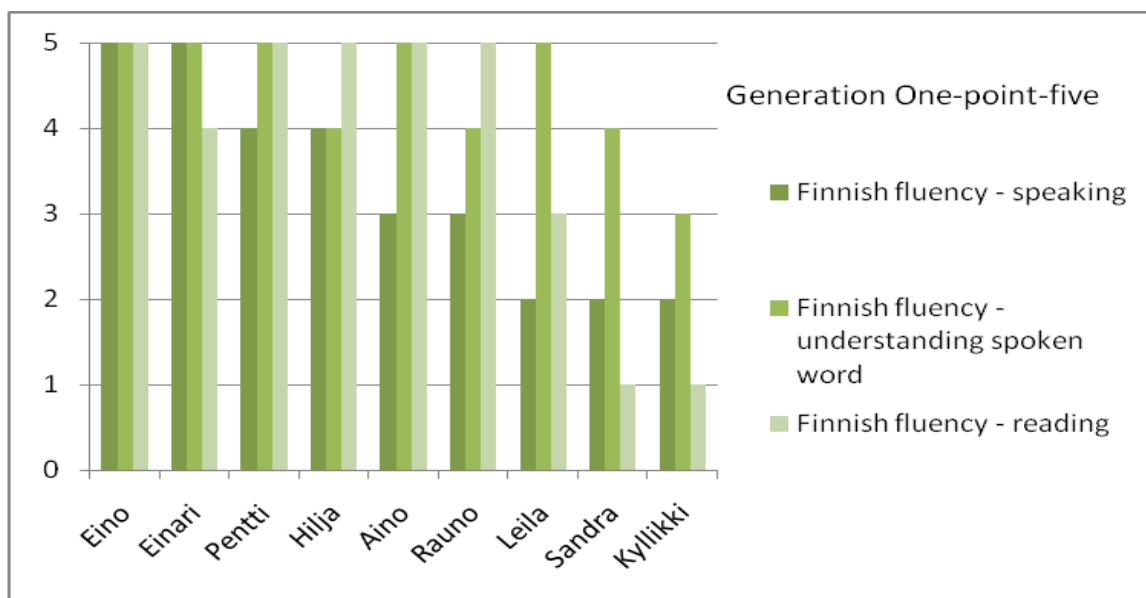


Figure 13 Gen1.5 Self-reported Language Fluency

All identified both their parents as Finnish. This group had an average of three children each, and therefore reported the highest fertility of the three generations. There was a range of highest

educational achievement: 4th form level, 5th form level, 6th form level, oppi koulu / finishing college, tertiary achievement at certificate level, and two bachelor degrees. Their most recent occupations included: Teacher, Supervisor, Technician, Administrator, Pulp and Paper Maker, Counsellor, Coordinator, Consultant and Manager. The Gen1.5 children who were on the cusp of adulthood on migration did not have as good education opportunities as the younger children, and started work soon after arrival. Three of this generation were retired, and the rest were still working at the date of interview. Education and employment show a move to high tertiary achievement, and a resultant move to more professional occupations than Gen1.

When Gen1.5 arrived in New Zealand they were aged between five and 18 years of age. Some of the younger participants did not have many memories of their time living in Finland, but they did remember certain smells and tastes, evidencing the embedded nature of experience. Of those with memories of Finland, they recalled not wanting to leave their friends, family or precious belongings. Many remembered being unhappy with their parents taking them away from the carefree and happy lives they had known in Finland.

Hilja (Sakari and Kaarina's daughter) who was nine years old when they left Finland, remembered getting letters from her Aunty and Uncle who emigrated to New Zealand four years before them, encouraging them to follow: "...it sounded like the land of milk and honey because my Aunty kept writing there was no winter, it's so warm, there's no snow, you don't have to have different sets of clothes." Like others in her generation, she remembered being angry at her parents and not wanting to leave Finland, her family and friends, and her precious belongings:

...because I had a really close bond with my Aunty and Uncle and my cousins (tears) isn't that funny I'm getting all emotional? Yeah. But that was okay because they had the same bond with us and they left to come here two years later, so that was good. But no, I was really angry with Mum and Dad for bringing me here.

Rachel, Hilja's sister, who was five when she left Finland, remembers very little about life in Finland aside from what she had been told. Like the other younger migrants in this generation, while she had no memories of places or events, there was a strong memory for smells that was still strong, even after 20 years. Pentti, the oldest Gen1.5 emigrant at age of departure, turned 18 on the first day of his trip to New Zealand with his family in 1962. Like the other participants, he remembered his days in Finland fondly and also that he was not very keen on leaving his good life in Finland, but he did not have much

choice. He recalled feeling as an 18 year that Kawerau was a dead-end place compared to the more social and cosmopolitan life he had known in Finland.

The trip to New Zealand was a great adventure, though sometimes frightening for some. Age and gender appeared to influence the recollected memories of the trip. The younger children on migration did not have many memories of the trip. The mid-aged children had more memories, and the girls remembered being fearful at times, as opposed to the boys who remembered it as an exciting adventure. The older children on migration did not have as many fearful memories as the mid-aged children. The group that came together on the Captain Cook tended to think of the trip as an adventure together with a group of friends, whereas the participants that came on their own tended to remember some fearful aspects of the trip.

Like the other boys of his age on the Captain Cook, Einari remembered thinking that the trip was a long great adventure to the other side of the world, and that he was excited to go because he knew many of the families who were taking the trip with them. He recalled the trip through the Rotomas, but unlike some others, through the eyes of a young boy it was exciting and fun: "...us kids were sort of having a lot of fun because all the twists and turns and we were sliding on the back seats from one side to another...". The somewhat barren construction site of Kawerau was also exciting through the remembered eyes of a child with piles of dirt to climb, heavy earthmoving machinery to admire, and a new warm environment to explore in bare feet.

The first school in Kawerau opened in February 1954, teaching 40 students out of a two-roomed pre-fabricated building. The influx of 28 Finnish children at the end of that year swelled the school roll significantly. Mrs Potter gave special instruction to the Finnish children in English and the 'New Zealand way of life', and two of the Finnish ladies (Mrs Elsa Kokko and Mrs Aune Karjalainen) joined the Parent Teacher Association. The children quickly learnt English and were noted for abilities in mathematics, handcrafts and sports. They soon made friends with children outside of the Finnish group, and were placed in classes across the school. Koivukangas (1996, p. 210) recorded that: "...after a year it was reported that there are no 'Finnish children' as a distinct group, and almost all understand practically everything that is said to them and receive no special attention." The Captain Cook group of Finnish children went to Central School. By the time the chain migrants arrived, North

School had been built, and where one lived in Kawerau determined which school one attended, further cementing the town's social stratification.

School and work were remembered as mostly positive experiences and although, for some, the early adjustment to the new environment was difficult at times, all quickly settled in. Many learnt more English through mixing with peers than from lessons, and many became English teacher and translator to their mothers in the early years. This appeared somewhat gendered, with the boys picking up English through making friends through sporting activities, and the girls assisting their Mums with learning English. School was a lot less formal in New Zealand and Liisa Rautjoki remembered jumping up to open the door for the teacher, an expected politeness in Finland, only to be laughed at by all the children in the class (Moore, 1991). The participants who came with the initial group on the Captain Cook seemed to settle more easily into school, possibly because special attention and classes were provided for the group, but not so for the individual chain migrants that followed. The initial language barrier presented frustration for some, meaning they had to be put back a class in school even though they were proficient in many subject areas already, like mathematics. Like many of the Gen1 women, some of this generation felt their education was negatively impacted on as a result of migration, due to the difficulties of learning English and a lack of further educational opportunities in Kawerau. Those so affected were older when they arrived in New Zealand, whereas the younger migrants slotted into the New Zealand schooling system just a little behind their peers, due to having to learn English. They soon caught up however, and went on to achieve well.

Hilja's story illustrated the experience of the chain migrant children. She remembered not enjoying the first year of school because she was already doing writing like calligraphy in Finland, and the teacher would take a red biro and slash it right across her work, because they were only taught to print in New Zealand at that age. She also remembered being hit with a wooden yard stick for a minor transgression and being completely horrified – nothing had ever happened like that in Finland. Due to her lack of English, she was placed in what she remembered as a 'baby class' with children around a year younger than her. However, the parts of the school work she did understand like mathematics was so boring because she had already done the work in Finland the previous year. The pre-fabricated school room with a pot belly stove for heating was in stark contrast to the modern multi-story centrally heated school she had left behind in Finland. She was also separated from the only Finnish child in her class which just added to her initial sense of isolation. Unlike the children who had come to New Zealand with the larger group of Finns, there was no special treatment for the children of the chain migrants that

followed. Hilja told me she was “rescued” by the Principal, Mr Ken Ion, who gave her one-on-one English lessons, encouraging progress by giving her special jobs to do like answer the school phone and make announcements on the public announcement system. As a result, her English improved considerably and by the next year she had become the top speller in her class. She also remembered having some special skills, like being able to knit gloves and socks with six knitting needles, which impressed her teachers and classmates. The theme of her narrative reflected many I heard, where the participants’ faced hardships but overcome them and went on to succeed.

Eino, like many of the younger and mid-age boys, remembered adjusting quickly to school and enjoying the warm weather and people in New Zealand, despite knowing no English at all when he left Finland. Sport gave him an instant connection with teenagers his own age and he reflected that: “...because you’re young you did not worry so much about not being able to speak you just went and played games – softball, batter-up, soccer or whatever – and you just went and took part...”. Aino, an older child on migration, reflected that her schooling was interrupted by migration, and commented that: “...when I left school, because I left school because the language barrier – it was such an awkward age 14 / 15 – I couldn’t pursue what I wanted to do...”

Outside of school and work, Gen1.5 reported they felt they were still in Finland in the early years, because of the activities of the close knit Finnish community. In the beginning, the migrants relied on each other for support, and so the traditional Finnish class differences from the home country were put aside in order to survive in the new environment. A number of Gen1 participants told me over the years about how your job dictated where you lived and how ‘high up’ you were in the social class system. Professional jobs, such as engineers, managers or doctors, were held in very high regard. Eventually, those differences bubbled to the surface as people felt more comfortable in New Zealand and the Finnish community, while still connected, was not as close as in the early years. The class differences were largely dissolved by Gen1.5 when all, except two of the participants, married non-Finns. This generation remembered feeling different because they were part of the Finnish community, and they were proud of this difference. While they looked to others like Pakeha or Kiwis, they had something special because of their Finnish heritage, sometimes in evidence to others around them by their Finnish accent (which depended on how old they were when they migrated) or their Finnish names. They mixed with the wider Kawerau community, particularly the boys who quickly involved themselves in sporting activities, and were well known for their sporting prowess. They continued some of the Finnish traditions, particularly Christmas Eve, sauna and Finnish food. Where the non-

Finnish spouses embraced the Finnish traditions, they were particularly strong in families. Mums took the lead role in continuing the Finnish family traditions, particularly as many were centred around food.

Hilja did not notice that many differences between Finland and New Zealand outside of school life in Kawerau, because she recalled mixing primarily with Finnish or other migrant families in the beginning. Rachel, Hilja's sister told me of the early years in Kawerau: "...the food, the culture, the language the celebrations and I think basically the family life. We had very little exposure to what life was like outside a Finnish home...". Hilja recalled one encounter with a Kiwi family where she was invited to stay over at their house one night at around 11 years of age, and phoning her Mum crying to come home after dinner: "And for the longest longest time, I never wanted to play with any New Zealand children because their mothers made funny food". As a teenager Hilja remembered feeling a sense of pride at being part of the Finnish Community and she "...realised that the Finnish group were making a mark in the town" and that: "...the Finns had a real name for putting on parties. And anyone who was anyone in Kawerau wanted an invite to the Finnish parties, and the reason was that the Finns put on such a fantastic spread of food that all the Kiwis just used to crave it". In the relatively small town of Kawerau, the Finns would have been recognised as a distinct group. She remembered feeling that things: "...just carried on as though we were just in a summer place which was like a little bit of Finland" and that the traditional celebrations continued around Christmas with Finnish hymn singing, candle lighting, sauna, acting in plays, the traditional food and the Pikku Joulus (little Christmases). Hilja remembered that Christmas Eve was great for her and her peers, because they could keep the Finnish traditions alive as well as celebrate with their non-Finnish spouses and families on Christmas Day. Hilja believed that whether or not other Finnish traditions were kept depended whether the spouses embrace 'Finnishness', particularly if the wife was a non-Finn. Some of the non-Finnish wives even elected to be called "Mummu" to their grandchildren, cook Finnish food and have Finnish artefacts in their homes. Where Finnish women of her generation had chosen to be called "Nana" Hilja said that is: "totally sacrilegious (laughing). It is almost a religion isn't it, being a Finn?"

While Rauno did take part in the Finnish community activities, he also had many non-Finnish friends, and remembered that: "...with the buddy system that we started with in school, you know that sort of followed through. I did not just have Finnish friends, I had a wider group..." playing soccer and getting involved with Kawerau community activities. He remembered that the Finnish community formed a basketball team which was only Finns for a while, but soon many other people wanted to join the team because they were very good. Aino remembered feeling like part of a Finnish community:

“We were the ‘different’ people...” and that even the Finnish homes looked quite similar, partly because of the Finnish items they had bought with them, but partly because of the department store show homes of furniture set up for the 17 Finnish families as part of the contract terms to provide furnished housing.

Eino remembered there was a strong Finnish community and he was involved with Finnish people, particularly relatives, but that he felt part of the Kawerau community as well. He reflected that: “...the Finns in New Zealand have been treated like part of the society. They haven’t been discriminated in any way”. Eino kept many of the Finnish traditions because: “You will never get rid of that because you were bought up to that. That will always be there – Christmases and Finnish food and Finnish culture and just the way the Finns do things, always be there”.

There was evidence of “linguistic longing” (Barkhuizen & Knoch, 2005, p. 216) among Gen1.5 and 2 for the Finnish language. All Gen1.5 viewed the Finnish language as important, and many regretted they did not teach their children Finnish. Once they married non-Finnish partners, English became the primary language spoken in the home and so their children did not grow up speaking Finnish. Adding to this, the Finnish Dads were often absent from home life when the children were younger as they were working shift at Tasman. The development of hybrid language terms referred to as ‘Finglish’ served to enforce the shared identity of the migrant Finns, but the loss of the Finnish language across the generations represented a loss of capital.

Hilja regretted not teaching her children and grandchildren the Finnish Language:

One thing that I’m really sad about, really disappointed in myself about, is that we did not take care of our language enough. Imagine if your kids could speak Finnish! Why did we not do that?...And that’s something I’ll regret - but nobody did you see. When we came back none of us spoke Finnish to our kids. We all started speaking Finglish. And the only reason I can speak good Finnish is because I went back (to Finland) otherwise I’d be like...the rest of them you know very very very limited.

Eino also regretted not taking the time to teach all his children the Finnish language:

That’s one thing that looking back now I probably would, at least make an effort, at the time when the kids were young they spent a lot of time with their Mum, I was on shift work and

during the day I was sleeping and so forth, and she did not speak Finnish. But looking back now, I would make an effort now, it would be nice for them to know at least a little bit.

Einari told me a story in response to a question on Finnish language ability while we were completing the questionnaire, both demonstrating the ubiquity of the narrative response (Reissman, 2008) and illustrating his pride and sense of Finnish identity revealed through language, even after living in New Zealand for 53 years:

I was in a bus travelling to Kotka...and there was this Finnish drunk in front of me...and he wanted to start speaking Finnish to me and so he told me his life story and he said “well where do you come from” and so I told him...I’ve been born in Finland but I’ve been living in New Zealand for many many years and this sort of thing. And after I’d sort of finished telling him my side of the story he said “I don’t really believe you” he said “you’ve got such a good command of the Finnish language – you’ve even got the accent from the Southern part of Finland”.

Despite my interrupting comment, and after a brief response, Einari continued with his story:

But, so anyway getting back to this bus trip I mean this drunk, well maybe he was too drunk, but he just did not believe me that I’d been away for such, for 50 well 45 years...Well I would say my language is fluent but possibly the writing is not up to scratch because I hadn’t kept that up to standard.

Table 4 Gen1.5 Conception of Identity

Gen1.5	Years Lived in Finland	Identity Conception
Hilja	9.5	A Finn living in New Zealand
Rauno	12	A Finn in New Zealand with roots firmly planted in Finland
Katie	6.5	Born in Finland and a New Zealander by choice (but not a Kiwi)
Aino	14	A Finn who fits into the New Zealand scene like Kiwi
Eino	13	In two minds, both a Kiwi and a Finn
Rachel	6	A citizen of the world with strong family ties
Einari	9	A Finn living in New Zealand
Pentti	18	In my heart I am a Finn, in my everyday life I am a Kiwi
Sandra	7.5	Proud to be a Finn and special to be different

Gen1.5 conceived of their identity in more heterogeneous terms than Gen1. Most Gen1.5 thought of themselves as in some part Finns, either through a connection to the land of their birth, or through their family relationships. For those living in New Zealand at the time of interview, most saw themselves as New Zealanders but not Kiwis; they told me they felt they were New Zealanders because they had chosen to live their lives in New Zealand, but not Kiwis because they were not born in New Zealand. Some felt that even though their children were born in New Zealand, they were not truly Kiwis either because they had been exposed to Finnish and / or other migrant traditions. A couple saw themselves as Finns but also Kiwis because of the lifestyles they led now. If they needed to make their lives easier, they would become New Zealand citizens, but they would not give up their Finnish citizenship or passport unless there was a good reason.

Hilja thought of herself as a Finn living in New Zealand:

I don't think of myself as a Kiwi, I never have...No one's ever pointed their finger or looked down their nose at me or said "you don't even belong here" – I look and sound like someone who has probably been living here all my life...That's never been a problem for me...so I don't know if I do Kiwi things, maybe I do, but I do them as a Finn living in New Zealand...and that's who I am. My kids are not Kiwi kids, my grandchildren are not Kiwis. They are New Zealand born of Finnish and whatever happens to be the mix of parentage.

Hilja reflected that she kept the Finnish traditions and thought of herself as a Finn, partly because of her close relationship to her parents, and the fact that she still spoke Finnish well, but also because: "...it's something that's in us. You know how Maori say they're of the land, they're the tangata whenua the land is theirs, well I'm of the Finnish land I can't help it - it's who I am". And that: "...I'm glad I'm a Finn because I think it's brought an extra added dimension of richness into our family – who we are...we have got a place to go, we have got a home. Finland is our home – we've got a home to go to". Even though Hilja strongly identified with being Finnish, and it added cultural capital to her life, like others of her generation she would consider becoming:

...naturalised without any qualms if it's what I needed to make my life easier. But while I don't need to, then I'm just proud to hold on to my Finnish passport and my 'Finnishness'. And in saying that, I know that a piece of paper saying I'm a naturalised New Zealander isn't going to make me less of a Finn...

Rachel did not feel a physical connection to the land of Finland, but saw herself as a Finn within the context of her nuclear family and within the Finnish genetic pool, as opposed to relationships with Finns in Finland or with the Kawerau Finns:

Yes it's all centred around the nuclear family and it's a very powerful nuclear family. So that's my sense of Finnishness, so am I a Finn? Yes I am definitely. How do I experience it? Through the family relationship...I think that because I do see it [the nuclear family] as the core from which the phoenix rose. I don't see myself separated from it. I see myself as integrally ingrained in it, and it ingrained in me.

While this could be put down to the fact that Rachel left home at 14 to go to boarding school, and then as a young adult re-migrated to another country, conceiving of identity through the nuclear family mirrored the experience of many of her generation. This concept of identity extended to her husband and child, and she desired to make every effort to remain connected to her child in the same way as she had stayed connected to her Mum and Dad, not necessarily physically (although that would have been ideal), but emotionally. In my observation of Rachel, her identity issues were worked through her transnational nuclear family relationships. She maintained close emotional bonds across the oceans by regular visits either in New Zealand, or meeting in other countries, and almost daily contact by email, skype and regular phone calls. The decision to re-migrate away from the nuclear family was not easy, and the intervening years did not ease the pain of separation. However, keeping close emotional bonds, having her own nuclear family, and feeling as though her parents gave her permission to leave and live her own life, did dull the ache. She had told her family that if her parents ever needed her, she would be on the next flight to New Zealand.

Rauno stated: "I still feel like a Finn but I do accept that I am a New Zealander, not a Kiwi, a New Zealander." He saw himself as a Finn in New Zealand – with roots firmly planted in Finland. Rauno's wife Katie told me she is:

...a New Zealander by choice, but I don't think of myself as a Kiwi. Not born and bred basically, not born and bred New Zealander which makes you a Kiwi but yeah because it is where we choose to live, I mean not initially because we came with our parents, but we've chosen to stay here...I guess that makes me a New Zealander.

Aino thought of herself as a Finn, and told me that: "I'm always aware that I'm a Finn. But I mean I fit into the New Zealand scene like a Kiwi really...I can never ever be anything else. You just can't be anything else, you're a Finn, you're a Finn". She cooked some Finnish food and kept some traditions,

but she also cooked other types of foods and kept other traditions and her identity as a Finn did not come from the things she did. She told me that: "...I don't have the Finnish flag flying or anything, not that patriotic. But you are what you are, eh".

Eino and Einari, like many of the men, reflected on identity in terms of work and sport and in this way identity conception appeared gendered. Eino stated: "Well, I'm in two minds. If the Finnish sports people are doing well, of course I'm a Finn (laughing)...". Einari associated following rugby and cricket with his Kiwi side, and also reflected on the differences between what he perceived as the Kiwi way and the Finnish way in his work experiences:

...and also in the work situation alright I think over the years I've developed a lot of the Kiwi way of thinking...in work situations and the logic that's used there. I know in some cases I've sort of felt that I'm sure if it was a Finnish management it would not happen like this but hey, so yeah.

Like their parents, returning to Finland for the first time was emotional seeing the land of their youth, even though much had changed. Visiting Finland was a ritual-like experience for many, although not all participants had visited Finland. While some had thought about it over the years, they all decided they could not return to live in Finland, because of the family they would leave behind in New Zealand, and also because of the cold Finnish winters. With the advent of skype, email and cheaper phone calls and airfares, some relationships for both Gen1 and Gen1.5 had been reinvigorated, and many kept in contact with happenings in Finland through internet radio and reading newspapers online.

Hilja had been back to Finland many times, and had some time ago said her "goodbyes" to Finland. On her most recent visit she: "...realised it did not matter what part of Finland I was in, it was just that I was in Finland, and everything there was natural for me. Nothing was odd or strange or unsafe, everything was funnily enough, like it is here, natural":

...but when I walk down [my home street in Finland]...I am there as a little kid. And in my eyes I see what I used to do.....could I live there? Would I want to live there? I would go in a heartbeat if my whole family followed me. Do you know, to be honest I don't think it would matter where I was as long as the whole family was with me.

Rauno remembered that the first time he went back to his hometown in Finland, 35 years after he had left, it was almost exactly the same as he had remembered it, with the only difference being that: "...there were only two ruts on the road, when we were there before there were three, where the horse used to trot in the middle". Katie and Rauno had been travelling to Finland more frequently once one of their sons had moved there. Reflecting on the recent months in Finland prior to our interview, Katie commented that: "It is in a sense, it's not quite home anymore you know we always come home to New Zealand but it's still a part of me even though I don't have any memories from my childhood of the place...". Like Rachel who was also very young when she came to New Zealand, Katie's memories of smell and taste endure even though she does not have any memories of places, people or events. When she went back to her hometown in Finland for the first time she remembered: "...the smell and the taste of the wild strawberries felt very familiar, and I don't know why, because for all I know I did not have any when I was a kid..."

When Eino first went back to Finland after 32 years of living in New Zealand, he felt quite emotional when he landed on Finnish soil. Subsequent visits were not as emotional however, because everything had changed so much and modern Finland did not resemble the Finland of his youth as much. He would not consider returning to Finland to live, mainly because the New Zealand climate was so good, although in other respects he felt he could easily adapt to life in Finland. Like many others, he kept connections with Finns through modern technology that were not kept before because he was not a very good letter writer: "It's only been just recently because of skype through the internet, and it's so easy, so easy...it is really good and that brings the world closer, definitely brings the world closer".

5.4. Gen2

Gen2 were all born in New Zealand and had one Finnish-born parent. They ranged in age from 27 to 47 years at the time of interview, with an average age of 37 years. Most had spent the majority of their lives living in New Zealand, and on average 47% of that time had been spent living in Kawerau. All had grown up in Kawerau and lived there at least until their teenage years, but many had then moved away as they reached adulthood for further education or job opportunities. Like their parents, this generation had partners from a wide range of ethnicities, and they identified with a number of ethnicities themselves including: European (2), NZ European (2), Finnish / New Zealander, Maori / Finnish, New Zealander, and Kiwi (2). While Gen1 and 1.5 were all married, Gen2 reported a mix of single (1), married (4) and de facto relationships (4). For those who had partners, they identified their ethnicities as: Kiwi (4), Indian / Kiwi, NZ European, Indonesian and South African. All identified at

least one parent as Finnish, and the other parent as a mix of ethnicities including: Dutch, NZ European, Kiwi (2), Maori, New Zealander (3), and Kiwi/Irish.

Unlike the previous two generations, most of this generation reported no religious affiliation, with only one describing themselves as Christian, one as Lutheran (neither practicing) and the other seven as having no religious affiliation. This group had an average of two children each, and their highest educational achievement was higher than both Gen1 and Gen1.5 including: Certificate level (4), Diploma level (2), Bachelors degree (2), and Masters degree. Most recent occupations included: Banker, Legal Secretary, Managing Director, Liaison Officer, Curator, Team Leader, Engineer, Consultant and Nurse. All of this generation were employed except one, who was a student at the time of interview. Employment was also available to Gen2 at Tasman, but had now become more restricted due to economic conditions resulting in downsizing. Wages, however, still rated well nationally and 57 years after the first Finns came to Kawerau many of their descendants, including my father and husband, were still being looked after by “Uncle Tasman”. There was a noticeable increase in qualifications for Gen2, and a consequentially steady move to more professional occupations, providing increased economic capital. The parents of Gen2 had both the means and motivation to support their children to achieve tertiary qualifications. All three generations enjoyed consistently good employment opportunities despite changes in the New Zealand and local economy over the years. Gen2 were fluent in their first language of English and they reported, with regret, that their Finnish language ability was poor.

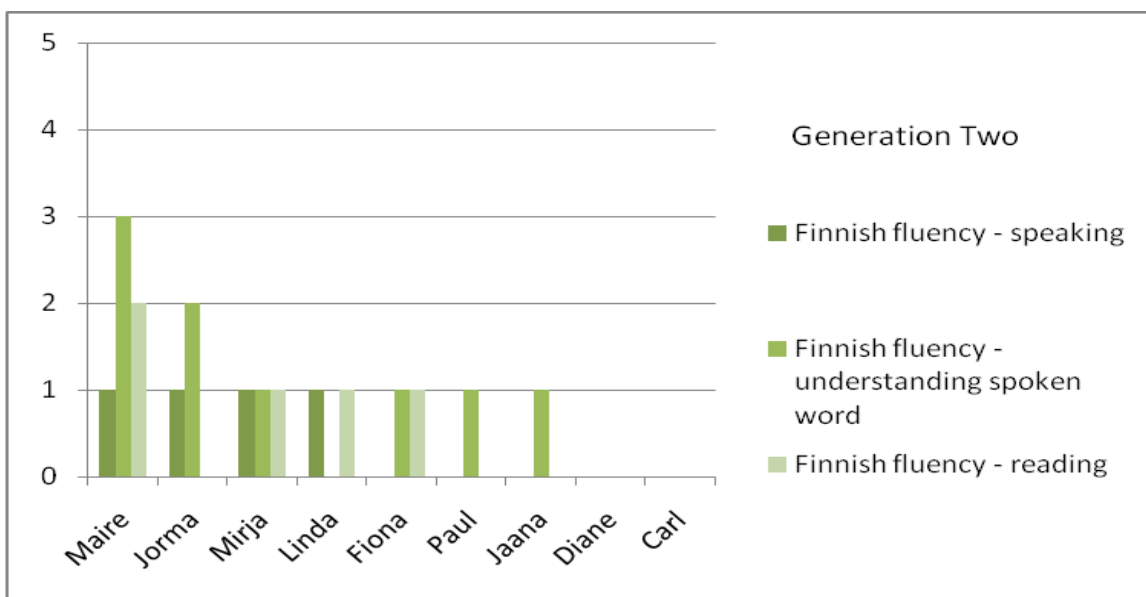


Figure 14 Gen2 Self-reported Language Fluency

By Gen2, identity was made up of many influences. Having been born in New Zealand, Gen2 conceived of their migrant experience through the stories of previous generations. Conceptions of their identity were informed by how they were brought up, and not necessarily where they were born. For example, if they were raised with what they thought of as European traditions, they identified with being European. They acknowledged all ‘sides’ of their identity through the birthplace of their parents, how traditions were practiced in their family, their Finnish name(s) if they had them, as well as the influences of being raised in New Zealand with the Kiwi laid-back lifestyle and the natural beauty of the country. Like their Finnish parent, they said it felt good to be slightly different and their sense of identity and belonging was made up of many parts. This was viewed as a positive and rich aspect to their lives.

Table 5 Gen2 Conception of Identity

Gen2	Years Lived in Finland	Identity Conception
Fiona	0	More Dutch than Finnish
Diane	0	Finnish blood running through her veins
Linda	0	A Kiwi with a Finnish background
Carl	0	Proud to be Kiwi, proud to be Maori and also proud to be Finnish
Maire	0	Many cultural influences
Jorma	0	A Kiwi with a Finnish cultural heritage
Paul	0	Mainly a Kiwi
Jaana	0	A Kiwi with Finnish traditions
Mirja	0.70	Both a Finnish and a Kiwi side

Many of this generation viewed the traditions in their upbringing as unique family traditions, as opposed to traditions specifically connected to being the child of a migrant parent or parents. Some fondly remembered feeling part of the Finnish community where they felt like they were part of a wider family group, engaging in traditional activities and eating Finnish food. Like the previous generations, close family relationships and rituals were important to this generation. Particularly the traditions of Christmas Eve, Finnish food, sauna and some giving their children traditional Finnish names, survive in some form in many of this generation. Gen2 had very fond memories of their Finnish grandparents, and these memories grounded them to their Finnish side. Some had visited Finland and felt some nostalgic connection to the stories they had been told as children of the home country, as well as finding some genetic similarity in facial features to the Finnish people. Others who had not been to Finland, communicated a desire to visit the places they had been told about throughout the years. The

visits to Finland, or the idea of visiting Finland, had the feel of a pilgrimage for many. Some were in contact with Finns in Finland, but the language still presented a barrier even though the younger Finnish generation spoke more English than previous generations, having learnt it at school. Many Gen2 wished they could speak Finnish, and felt that if they could they may have considered spending some time living and working in Finland.

Fiona thought of herself as European, and not Kiwi, because she was brought up with European traditions by a Finnish mother (Hilja) and a Dutch father. She did not think of the traditions she continued in her life as being especially the result of being the child of a migrant, but more as family traditions: "...because they're my traditions now. It's part of me. I don't think it's...because I'm from a migrant family, it's just because that's part of what our family does. So that becomes part of my family traditions...". Like many of Gen1.5, Diane recalled her family as being more open, particularly around nudity and the sauna culture, than her friends' families, and that she felt part of a wider Finnish community where: "Everyone got together and everyone knew everyone". She remembered fondly those times of wider Finnish community with the special food and get-togethers, and wished her children were able to have that same opportunity. She would like to visit Finland one day to go to the places she had heard about in stories about the home country from her Dad. Diane did not see herself as a Kiwi or Pakeha, but rather as a New Zealand European, acknowledging both her Kiwi Mum and Finnish Dad. She continued a number of Finnish traditions in her family, including the sauna tradition, but told me that, like Fiona, she is not sure whether many of the things she does is: "...really a Finnish tradition or if it was just the way the family was".

Linda told me she saw herself as a Kiwi, although she acknowledged her Finnish background: "...partly due to being exposed to some of the traditions and the food and the Finnish celebrations I guess growing up...". Like others interviewed, Finnish Christmas traditions with the extended family were important to Linda, as well as Finnish food and even though she did not make it much herself, her Kiwi Mum has been teaching her son how to bake pulla. Linda had been to Finland and enjoyed seeing the places where her Finnish father (Eino) and grandmother grew up, as well as visiting family members. She enjoyed the connection to family as well as hearing the familiar Finnish language and eating the familiar Finnish food. She felt a genetic connection to people in Finland, who appeared to her to have physical traits similar to her. While she enjoyed her holiday, she told me that: "Home for me is always New Zealand".

Carl, who had a Maori father and a Finnish mother (Aino), felt a strong connection to the Bay of Plenty through the people, land and environment. He saw himself as different because he was, in some ways, Pakeha (but not British), in some ways a New Zealander and also Maori. He told me people mostly perceived him as Maori but that he had, at times when overseas, been noticed for his high cheekbones as a typical Finnish facial feature. He felt comfortable being in-between, feeling both different but totally accepted which added cultural capital to his life:

And I suppose that's why I'm sort of caught in-between everything. So yes I'm Maori and I'm born and bred here, but I'm also Finnish, and I'm a New Zealander. I'm proud to be a Kiwi, I'm proud to be Maori and I'm also proud to be Finnish – there's no doubt about that.

Thinking about his Finnish 'side', Carl, like the other participants, identified with Finnish food and celebrations, particularly Christmas Eve and memories of the Kawerau sauna with his Finnish grandparents when he was a child. He also wanted to carry on a connection to his Finnish roots through the names he chose for his children. Even though Carl had never been to Finland, he would like to go, particularly to see his grandparent's house and the places talked about in family stories and told me: "I think I will go back. I want to go and see where we come from, and I want to go and see the...it is a bit of a sort of yearning". He kept up some family contact through phone calls with the younger Finnish generation whose English was good.

Maire, Einari's daughter, put her affinity with all things Finnish down partly to her Kiwi Mum who really embraced Finnish traditions: "...right through from decorations on the wall through to Christmas celebrations through to learning all the baking so...I always say to people that I've grown up in a bi-cultural household". Like others of her generation, Maire wanted to give her child at least one Finnish name, most likely an older Finnish name from the almanac that was easily recognised as Finnish as opposed to a more modern Finnish name. She was proud of her own Finnish name and always made an effort to ensure it was pronounced correctly. She saw this as a way of keeping connected with her Finnish heritage. She also planned to keep up the Finnish family traditions, particularly around food, Christmas and sauna, with her own family into the future so her children could experience some of what she had enjoyed. Having a European partner, she also wanted to ensure some of those traditions were carried on with their children as well. Musing on the concept of being a New Zealander, she reflected that there is no one fixed view or concept in her view, but rather being a New Zealander is the willingness to be open to identity being made up of many parts. In her case, there was the Finnish influence, Maori cultural influence, her designation by some as a Pakeha, and the colonial view from her Mum's English / Irish / Scottish heritage.

Jorma, Maire's brother and Einari's son, remembered feeling different as a child growing up in the small town of Kawerau because of his Finnish heritage, and particularly his noticeably Finnish first and last names which people had trouble pronouncing properly. Despite this, Jorma told me: "...I enjoyed having an affinity to a different background because it did make you feel like you were a part of something else..." and the older he got the prouder he became of his cultural heritage. Jorma first visited Finland when he was 36 and had recently been back as well, only 3 or 4 months before our interview, primarily to visit his Mummu. He remembered his first visit to Finland being somewhat emotional because it was the first time saw all the people and places he had heard about in family stories all his life: "...I did feel like I was getting in touch with my roots...and it did feel a little bit emotional..." finally going to the place where the other half of you is from.

Like Jorma, Paul associated being Finnish with his last name which is difficult to pronounce and spell for New Zealanders. He would also like to go to Finland one day because, like many of the other participants, he would like to see where his father Pentti grew up, and see the places that have been described in family stories over the years. Like Jorma and others, he had very fond memories of his Finnish grandmother:

We used to love going to see Mummu. There was always something nice there to eat, it was always a happy place to be, everything was good. We used to enjoy it yeah, we'd go there and Mummu would just always be happy to see you, real happy person, so it was always good to go there.

Like many of the other participants, Paul and his wife had given the children either first or middle Finnish names. This was to recognise their heritage, but also to have a different name as well as a name that somehow 'matched' their Finnish surname.

Jaana, like many other participants, had fond memories of growing up in the Finnish community in Kawerau. She reflected it was a bit like being part of an extended Maori whanau because she had many Finnish 'cousins' even though they were not technically related. She thought of these relationships as closer than friends, and more like family. Jaana remembered loving the points of difference having a Finnish Dad, like going to sauna and being brought up open minded about nudity, and having distinct names that were clearly not Kiwi. She remembered being very proud of the Finnish dads who played basketball and were well known in the town:

...they were really cool because they all played basketball together and it was like they were known and you meet people now and they go “oh I know your Dad he was one of the Kawerau Finns” and...it makes us really proud you know, it’s cool, it’s really cool to be different. But then people say “can you speak Finnish” and I say “no” and then I’m really embarrassed (laughing) and wish that I could!

Things felt comfortable for Mirja when she went to Finland as a young adult because her family and the wider community welcomed and accepted her as a Finn because she looked Finnish, had a Finnish name and could speak a little Finnish. She felt privileged to be so accepted as she noticed while there foreigners who looked and sounded different to Finns were generally not accepted so easily into the small northern town where her family lived. While staying with family an opportunity came up for her to attend a Finnish language school for foreigners, learning language, history and culture, and so she stayed to attend the course and later to work in a Finnish hospital for a time:

And I lived in the house where my Dad was born and bred with my grandmother or Mummu I should say, and my Uncle upstairs, so then I felt like I was living a little bit of the life that my father would have. The course happened to be held at the tech where he had done his instrumentation training so I was living in the house that he had lived in and I was studying in the place he had been and I was biking and doing the same circuits that he would have been, probably going to some of the same pubs (laughing) and walking the same forests and collecting berries and it was really just a neat time.

Mirja struggled to put into words what made her feel like a Kiwi, but she did a number of things to keep the Finnish traditions alive in her family. She kept in touch with the Finnish Society, taught her children some Finnish language and traditional baking and cooking, and kept up the Christmas traditions: “...just the little things, trying not to let the Finnish culture just sort of slide away, just trying to keep some of it in my life”. She described it as: “I think I predominantly live as a New Zealander with a Finnish influence”. She kept up the Finnish traditions for herself and her children but also for her Dad, and commented that:

...I think the dads can get lost in the family unit. I think, you know, the Mum is often the quite dominant person, so I think particularly for them it’s nice to have a time where especially with Dad being the only one Finnish, that he actually feels important, and feels that that is important to us too.

5.5. Summary

An analysis of narratives in this chapter revealed how a group of people made sense of their shared migrant history as they utilised various forms of capital to ‘play the game’ in the field of migration. The group’s habitus was enabled by the power and resources provided by good access to economic, cultural and social capital over time. Aspects of capital were revealed to be passed down and between generations, and as a shaping force for identity and belonging.

Despite post-war conditions in Finland, most Gen1 had good jobs and lives when they left and their economic capital only increased in Kawerau with lifelong access to well-paid employment, as well as other advantages such as interest free housing loans. On the surface, the decision to migrate was in response to employment and adventure, however, narratives revealed some felt there was an element of fate to their decision. This idea of fate was balanced with a sense of control over their life decisions, supported in part by their access to economic resources. Economic capital also allowed Gen1 to provide educational opportunities for Gen1.5 resulting in higher levels of qualification and employment, and in turn Gen2 experienced even greater educational and employment opportunities than previous generations. In this way, the economic capital of previous generations provided a protective factor for future generations to weather the worsening economic situation described in the previous chapter.

Tasman support for settlement, and the resultant contributions of capital, enabled Gen1, and particularly those who came on the Captain Cook, to lay the foundations for those who were to come later. A familiar social stratification to that which they had known in Finland provided Gen1 with cultural competence on arrival in Kawerau. However, narrative revealed an even greater cache of cultural and social capital when participants explained how the traditional Finnish class system was put aside in the early years to build a strong Finnish Community. The formal and informal structures of the Community supported the process of settlement, and also contributed a sense of identity and belonging in the town of Kawerau where Gen1 felt simultaneously part of New Zealand society and retained their essential sense of ‘Finnishness’. This was particularly important for the women. While the men and children received English lessons and had social and language interactions at work and school, the Community was the primary source of assistance and social connection for the women in the early years. There was some loss of capital as a result of migration with the loss of the Finnish language across the generations; a number of participants spoke of how they regretted not being able to speak Finnish or not having taught future generations.

Gen1 felt changed by their experience of migration, acknowledging they could not go back to the ‘same footsteps’ they had left; they acknowledged, but were comfortable with, their betwixt and between position – neither Kiwis nor the same as the Finns they had left behind in Finland, but a new comfortable hybrid. Gen 1.5 also felt fully accepted and competent in both New Zealand society and in the Finnish society that had developed in Kawerau through the Community. By Gen2 their sense of identity was based on their unique family traditions which were influenced, in part, by their parents’ and grandparents’ experiences of migration through the capital provided by the Finnish Community; these practices as well as relationships gave them a sense of belonging as people in New Zealand society with a rich migrant background which they were proud of. In this way, the nature of capital was shown to transfer down generations and to have an impact on identity and belonging.

However, this transfer may not only be one way. The migration experiences presented opportunities for Gen1.5 to introduce new patterns and practices to Gen1, thereby affecting the development of their habitus. For example, their exposure to new ways of thinking and acting at school and their quick uptake of English meant they were able to act as teacher and translator for their mothers who had not benefited from English lessons. Children took on the role of ‘cultural ambassador’ through experiences with school, language and social situations that their parents were not exposed to illustrating that capital transfer may be multidirectional in the field of migration. This transferable nature of capital is further explored in the following chapters.

This chapter illustrated the usefulness of both narrative and habitus as theoretical constructs for revealing how people give meaning to experience, and how generational patterns of thinking and acting are influenced by histories and ‘sedimented’ by past experiences. The next chapter continues to tell the story of this multigenerational group by investigating how food, as a cultural symbol and a form of capital, provides a sensory and embodied connection to being Finnish that strongly connects to constructions of health.

Chapter 6. Food as Symbolic Capital

An analysis of narratives in the previous chapter revealed that capital can be passed down and between generations, and can also influence a sense of identity and belonging in the field of migration. The chapter also found evidence of a number of changes across the three generations with regards to Finnish cultural symbols such as sauna, the Finnish language, and the Lutheran Church. These changes were the result of various factors including migration, intermarriage, assimilationist and then bicultural Government policy, as well as moving away from Kawerau, resulting in the scattering of the Kawerau Finnish community. In contrast to the changes undergone by many symbols of Finnish culture, the symbolic notion of Finnish food persisted across the generations. This chapter explores food from the theoretical constructs of habitus and culture as a key symbol, being part of a cultural toolkit, a form of capital, and a contributor to conceptions of health. The chapter discovers how participants accumulate and transmit food symbolism between generations through the subtle teachings of the everyday sensory experience of food. The objective of exploring both migrant and health experiences through the symbolic lens of food (which emerged from participant narratives) is also addressed in this chapter.

6.1. Food as a Key Symbol

Finnish food provided a way to practise “symbolic ethnicity” (Gans, 1979), and these symbols were extracted and abstracted primarily from the first generation. Gen1.5 and 2 then drew on them as “easy and intermittent ways” of revealing their ethnicity (Gans, 1979, p. 8). Ortner (1973, p. 1338) proposed that: “It is by no means a novel idea that each culture has certain key elements which, in an ill-defined way, are crucial to its distinctive organisation”. She described the following five indicators of cultural interest, and proposed that key symbols can be identified by more than one of the indicators:

The natives tell us that X is culturally important; the natives seem positively or negatively aroused by X, rather than indifferent; X comes up in many different contexts. These contexts may be behavioural or systemic: X comes up in many different kinds of actions situation or conversation, or X comes up in many different symbolic domains (myth, ritual, art, formal rhetoric etc.); there is greater cultural elaboration surrounding X, e.g., elaboration of vocabulary, or elaboration of details of X’s nature, compared with similar phenomena in the culture; and there are greater cultural restrictions surrounding X, either in sheer number of rules, or severity of sanctions regarding its misuse (Ortner, 1973, p. 1339).

Food was culturally important to all three generations, as evidenced by its use as a symbol to represent the migrant experience, identity and a sense of belonging. It also came up in many different contexts

through narratives in the fields of both migration and health. Gen1, in particular, seemed positively aroused by food rather than indifferent, and it appeared in narratives as a symbol of identity and belonging across all three generations. There is greater cultural elaboration surrounding food, as opposed to other cultural symbols such as sauna, and it is the only symbol that persists across all participants across three generations in the context of their migration and health experiences.

Food as a key symbol was also revealed in synesthetic²⁶ terms (Sutton, 2010) and was concerned with: "...everyday life and the multiple contexts in which the culturally shaped sensory properties and sensory experiences of food are invested with meaning, emotion, memory and value" (Sutton, 2010, p. 220). Food was touched, smelled, tasted, remembered, shared, used to mark occasions, used in health keeping, and therefore provided a context within which migrant and health identities were constructed. Food was an ethnic marker to some degree across all three generations, and food-related rituals celebrated a sense of belonging in the migrant context. As Rabikowska (2010) found in her study of Polish migrants, experiences and memories of Finnish food were acts of ritualised belonging for the participants, and an expression of their 'otherness'.

Food can be thought of in terms of Bourdieu's (1986, 1999) theory of habitus and the concept of capital. Christensen (2011, p. 470) stated that: "The family acts as one of the most important sites of accumulation and transmission of capital, and it is central to the formation of the habitus according to Bourdieu (1996)" and proposed that: "...lifestyles regarding body formation, physical activity and food tastes are transmitted from parents to children who will reproduce their parents' behaviour" (2011, p. 470). Wilson (2010, p. 264) see also (Backett-Milburn, Wills, Roberts, & Lawton, 2010) proposed that:

As dispositions inculcated from infancy, how we treat, care for and feed the body reveal some of the deepest dispositions of habitus (Bourdieu, 1984, p. 190)...Food continually renews social bonds, essential for collective mental and physical health, strength and vitality, producing a visceral sense of embodied satisfaction.

Habitus is internalised in individuals through childhood socialisation in the family group, and is durable and transposable throughout life, although never immutable (Sallaz & Zavisca, 2007). Food could be thought of as both a cultural symbol and a form of capital. 'Food capital' could be transferred across generations, through the subtle teachings of the seemingly mundane everyday embodied food

26 A union of the senses, food is taste, smell, colour, texture and temperature.

experiences (Bourdieu, 1989, 1990b), and this could aid in understanding how groups pass on eating practices and understandings about food and the body (Meinert, 2004; Shilling, 1993; Wacquant, 1995). Lupton (2003, p. 45) commented that:

Bourdieu theorises that if one belongs to a certain group and identifies with that group, then one will make choices in everyday consumption rituals which reflect the habitus of this group.

6.2. Finnish Food Created in the Migrant Context

The concept of Finnish food has evolved through the experience of migration, and is one aspect through which migrant identity and belonging is revealed:

...knowledge and experience of food comes first from home (whatever kind of home it was) whose memory is later perpetuated, contested, and negotiated in different ways. This is both a social and a personal experience which among many other cultural, political or religious experiences contributes to the net of social relationships and to our identities (Rabikowska, 2010, p. 378)

What the participants think of as Finnish food is actually unique to the migrant group, even though there are still many similarities with traditional Finnish food in Finland (which has also evolved over time). The evolution of the Finnish language by the migrants into 'Finglish' was discussed in the previous chapter. Some of the migrant Finns also felt, when they visited Finland, that their personalities had changed as they found friends and family to be formal and reserved, whereas they had become more casual and outgoing as a result of their migrant experiences. This is further revealed in the next chapter, where the traditional Finnish characteristic of perseverance has developed into optimism through the migrant experience. In the same way, the traditional Finnish diet evolved in the migrant context.

When Gen1 arrived in Kawerau they could not buy the food they were used to; they could not even get some of the ingredients they needed for Finnish dishes and baking such as rye flour. Therefore, recipes had to evolve. Many of the women had to learn home baking and sewing, as they had been used to buying the traditional baked goods, such as pulla²⁷, as well as ready-made clothes in Finland. Such luxuries were not available at that time in Kawerau, but due to the demand, shops began to stock

²⁷ See Appendix Six for the pulla recipe my family uses, however, there are many variations

specific items for the Finns such as yeast blocks, rye flour and cardamom over time. The three generations of migrants, and even some of the next generation, developed skills in Finnish baked goods that many Finns in Finland may not possess because of the availability of Finnish foodstuffs in the shops. When I visited Finland in 2008 and 2012, I was amazed to see pulla, as well as many other traditional Finnish dishes, being sold in the supermarket – no one we came into contact with in Finland baked pulla at home. For many of the Gen1 women, however, baking pulla was a weekly task when they arrived in Kawerau. The tradition of baking pulla has persisted, even to some in the third generation who have been taught by the generations before, often by their Mummu.

There is a gendered aspect to food for the participants. Particularly for Gen1, in the early days the cooking and baking were done by women, and their reputations in the Finnish Community were predicated on their abilities, particularly in baking. While the men worked and the children went to school, the women looked after the home and engaged in the many activities of the Finnish Community. This provided ample opportunity to showcase their baking abilities. I remember women in the Community being known for certain specialties, which are still talked about today, even though many of the women have long since died – “oh yes remember Mrs so and so, she always made the lovely vineries (pastries)”. Even certain dishes prepared by certain people for certain occasions are still remembered – “yes Mrs so and so did make the proper rye bread, remember she made all the bread for so and so’s wedding...” Discussions about events such as weddings, funerals and baptisms would not be complete without some reminiscence of the food that was prepared by certain people. While all the Finnish women baked, at Community occasions people who were known to be particularly proficient at certain dishes would provide those. It was an unspoken rule that you would bring what you were considered good at making.

When I talked with Niilo about food, he wanted to know if I could make Karelian Pies, a favourite of his. He reminisced about how well a person in the Finnish Community could make the pies – she had a reputation for making these pies even better than he had tasted in Finland, according to Niilo. He equated this ability with her being a “good girl”. Being able to make Finnish food is still thought of as a desired trait in women with Finnish heritage, and people are often talked about as having talents in this regard through families. For example, when I cook a meal or bake something, my extended family tell each other that I am just like my grandfather’s sister, who had a reputation as being a very good cook. In this way, the ability to produce food that is acknowledged as being of good Finnish quality, contributes to a sense of identity and belonging in the field of migration.

Diet evolved in the field of migration. Most of the 20th Century Finns had preferred to raise animals rather than plants for consumption, due to the climate and soil being less suitable for plant production, and more suitable for growing forests and raising animals. As a result, a national diet rich in fats was viewed as the cause of the prevalence of coronary disease (Solsten & Meditz, 1988). Gen1 expanded their pre-emigration diet to include a wider variety of fruits and vegetables which were more widely available in New Zealand due to the warmer climate. Sakari remembered that he: "...started to eat more different kind of fruit and veges, more [than] what we did, particularly in wintertime, in Finland" and he conveyed that this dietary change as a result of migration contributed positively to his health. They already understood that certain foods were beneficial for health, but many were only seasonally available in Finland. This was illustrated by Sakari's recollection of his childhood as being very favourable (and not all participants had such a favourable childhood) in terms of the consumption of health-promoting foods such as fish, berries and wild venison:

I probably was in very favourable place, particularly summertime, eating all those wild berries in bush, roughly four / six months per year, and naturally they were collected. They were wild berries were on diet around the year and [in] my case, because of the family occupation, eating plenty of fish and wild venison, and naturally have to say because I am a Finn that rye bread being on diet beginning of time.

When Gen1 emigrated, the link in medical science between diet and the prevalence of coronary disease had not yet been made, or at least was not yet in the public domain. In my observations, Gen1 responded to various public health campaigns in later years, both in New Zealand and through their transnational connections to Finland, and moved steadily to a lower fat diet. This was reflected in their change of Finnish recipe ingredients. For example: substituting low fat milk for cream, substituting margarine/oil for butter, trimming fat off meat, and eating a wider variety of vegetables. Their change in diet was also likely influenced by their vigilance in later years in monitoring the "Finnish curse" of high blood pressure and high cholesterol, exposing them to advice from health professionals and other sources such as public health media campaigns, on low-fat diets designed to lower cholesterol, blood pressure and weight. Tastes had also changed over time. I observed over recent years that some traditional Finnish recipes had been thought to be very plain in flavour, and had been adapted to include herbs and spices not traditionally used. A number of the Gen1 and 1.5 participants told me that when the Finns first arrived in the 1950s, their dishes were thought to be very exotic by the locals, illustrating how times and tastes have changed in New Zealand with the wider availability of foods.

6.3. Food as a Cultural Symbol

Mintz and Du Bois (2002, p. 109) asserted that cuisine can provide concreteness to the ‘imagined’ concepts of ethnicity and nationhood:

Ethnicity is born of acknowledged difference and works through contrast. Hence, an ethnic cuisine is associated with a geographically and/or historically defined eating community. But ethnicity, like nationhood, is also imagined – and associated cuisines may be imagined too. Once imagined, such cuisines provide added concreteness to the idea of national or ethnic identity.

For Gen1, Finnish food traditions connected them to the home country, formed part of their identity as Finns, and served as a source and marker of social distinction and belonging in the town of Kawerau. They had not realised the distinctive ethnicity of their food until they left Finland, because, as described by van den Berghe (1984, p. 395):

...the consciousness that one has an ethnic cuisine can only come from alien contact. Ethnic cuisine is thus an excellent paradigm for ethnicity itself. It is only fully realised through alienation. The boundaries of the familiar only become known through contact with the unknown. It takes a ‘them’ to define an ‘us’.

For Gen1.5, Finnish food traditions connected them to the memory of Finland, but also to the memory of growing up in the Finnish community in Kawerau, and formed part of their identity as Finns living in New Zealand (or elsewhere). For Gen2, Finnish food traditions connected them to their upbringing in Kawerau, as well as nostalgia for the Finland they knew through vicarious memories created by the stories of their Finnish parent and/or grandparents. Along with other influences, the Finnish food tradition formed part of their mixed identity. Out of all the Finnish traditions Gen1 brought with them to New Zealand, food traditions persisted across all three generations, particularly the traditions associated with Christmas Eve celebrations. From my observation, there was a change apparent across the generations with the consumption of Finnish food. Gen1 ate Finnish food as part of their regular diet, as well as special dishes on special occasions. For Gen1.5, less was consumed on a regular basis, but having special dishes on special occasions persisted. By Gen2, most Finnish food was consumed on special occasions, particularly Christmas Eve.

For Gen1, Finnish food distinguished them as cosmopolitan and exotic in the town of Kawerau on settlement, and was something unique shared mostly amongst the members of the tight knit Finnish Community. What they had viewed as ‘normal’ food in Finland, was now being celebrated – it was not

until the Finns were relocated from the national/homely environment that they realised they were recognised by categories that they had not considered before i.e., exotic. Smells, tastes and memories of food were inextricably intertwined with the home country, and this was revealed in the early years by longing for certain foods as an expression of homesickness. Christmas packages would arrive from Finland, containing precious delicacies not available in New Zealand in the early years. Sending foodstuffs as gifts continues to the present day; despite the global marketplace there are still many Finnish foodstuffs that can only be purchased in Finland. Enjoying eating Finnish food was one of Gen1's strong and enduring memories of their first trips back to Finland many years after migration. They conveyed that continuing the traditions of celebratory Finnish food, particularly around significant events, were important to them and formed part of their identity as Finns. This created a sense of belonging in the Finnish Community in Kawerau. Eating Finnish food for Gen1 was a sensory memory of their lives in Finland, and when they ate it they felt like they were home. This illustrates how the sensory aspects of food can construct a sense of place, and can reveal identity.

Some of Gen1.5 participants, who were very young when they emigrated, did not have many memories of their time living in Finland, but they did remember certain smells and tastes, and they reported that these sensory memories persisted into adulthood. They remembered Finnish food as a point of difference between them and non-Finns, and that Finnish food was an integral part of family and Finnish community events. They felt a sense of pride in Finnish food, and thought that non-Finnish food was "funny" when they were children. Like Gen1, the family traditions of food, particularly around Christmas, weddings, funerals and baptisms, remained important to them as a representation of their identity as Finns, even when they married non-Finns. The traditions were particularly strong in families where the wife was Finnish, or where the non-Finnish wife embraced Finnish traditions, as illustrated by Einari's comments:

Well I would say, in all honesty, that because I've married a New Zealander and my wife is so pro-Finnish alright, more so than some of the Finnish people are because she wants to learn the Finnish cooking and the sort of things so it's not so much because of me, it's more so of my wife...My wife does Finnish rye bread she's just finished doing a batch. She does all the Finnish pullas and all the Finnish Christmas food the lanttulaatikkos²⁸, perunalaatikkos²⁹ and the paisti³⁰ and tortut and rosolli and everything else.

28 Lanttulaatikko is a baked turnip casserole

29 Perunalaatikko is a baked potato casserole

30 Paisti is roast meat

Pulla is a mildly-sweet Finnish dessert bread flavoured with crushed cardamom seeds, cinnamon, and occasionally raisins or sliced almonds. There are many variations and pulla is a staple food of the Finnish home. Tortut are tarts and there are also many variations. However, for Christmas, they would contain prune filling. The recipe for tortut evolved in the migrant context from being made with a butter pastry to one using cottage cheese. Rosolli is a Finnish vegetable salad, with a main feature of beetroot that sometimes includes a dressing made with whipped cream and is usually found at the Christmas table. Piparkakku is a ginger biscuit that is also made at Christmas in the traditional shapes shown below. Rye bread is made all year around, but special recipes are made for the Christmas table or for birthday or other celebrations, where it is served as open sandwiches including a variety of toppings such as salted salmon.



Figure 15 Pulla



Figure 16 Tortut



Figure 17 Rosolli



Figure 18 Piparkakku



Figure 19 Rye Bread

Despite a more heterogeneous view of identity than Gen1, as shown in the previous chapter, the importance of food as a key symbol for identity persisted in Gen1.5 as illustrated by Eino who stated: “You will never get rid of that because you were brought up to that. That will always be there – Christmases and Finnish food and Finnish culture and just the way the Finns do things, always be there”. Gen2 conceived of their migrant experience through conceptions of their identity, which was informed by their unique family traditions, including eating Finnish food, particularly on special occasions. Some fondly remembered feeling part of the Finnish Community, engaging in traditional activities and eating Finnish food. Their memories of their Finnish grandparents, which connected some of them to their Finnish side, were inexorably linked with Finnish food from their Mummu’s

kitchen. Many of this generation viewed Finnish food as one concrete way to keep the Finnish side of their identity alive for themselves and the next generation. As a second generation Finn, I cannot separate the smells, tastes and rituals of food from my experience of being a Finn. One of my earliest memories is sitting at the kitchen table at my Mummu's house with the smell of cinnamon and yeast in the air being given dough to roll out for the weekly pulla baking ritual. I would always get to eat a little of the dough (but not too much I would be told or I would get a sore stomach) and I would help by fashioning my own misshaped little pullas for the baking tray to sit alongside the rows of little brown swirls on the kitchen bench as they cooled off under special tea towels. I never remember a time that there was not pulla at Mummu's house – for me, it is a ubiquitous symbol of family life. Following the gendered tradition, my Mummu taught my Mum, me and my daughter how to bake pulla at that same kitchen table. However, we do not bake all that often even though we know how because Mummu still supplies us all with pulla regularly. Before my daughter went to University this year she spent a day with Mummu and they baked a box full of pulla for her to take with her and put in the freezer so she would not be without a taste of home during the school term. Every holiday home she has spent a day with her Iso-Mummu baking pulla.

6.4. Food and Health

Food comes up in many different contexts, both as a representation of migrant identity and belonging as discussed above, and in conceptions of health as discussed in this section. According to Gen1, anything that enters the body, either via the mouth or other orifices, or through the skin, can influence health either positively or negatively. Food, therefore, can directly influence health, according to the participants. All three generations talked about there being a link between food and illness, and many would look to food as the cause of illness when engaging in self-diagnosis. They also discussed that food could help avoid illness, and even counteract some of the negative impact of genetics, which, according to their accounts, had developed as a result of the poor diet of their ancestors. This was one of the reasons they gave for having evolved their diet in the migrant context. They also alleged that the nutrition they received in childhood (or did not receive in wartime for Gen1) affected their lifelong health. Eating a healthy diet, as part of a balanced and moderate lifestyle, formed a consistent element of their lay conceptions of health across all three generations (further discussed in the next chapter).

Both Sakari and Kaarina held that there was a link between dietary habits and specific illnesses such as gout and heart disease. Kaarina said that to be healthy you need to: "...eat healthy food and be moderate with your eating" and that a bad diet could cause many illnesses, although some could also be

the result of genetics. She reflected that: "...there are heart problems here too, you know, in New Zealanders, high cholesterol, and all comes from diet. I have high cholesterol too, even though I don't eat so much, so I don't know how much it is inherited or how much it is your own fault when you get those illnesses so...". Mikko stated: "Usually I feel if I eat something that my body does not like that one, I just avoid it and I lose straight away the problem". He credited his good health to being active, watching what he ate, and good inherited genes from his parents. His wife Aila told me that both she and Mikko ate very healthy food and walked every day, and while she did not hold that this would cure illnesses necessarily, it helped them not to get sick.

Hilja (Gen1.5) communicated a connection between food and health in her narrative on what she did to maintain her health. Her narrative revealed a moral aspect as she outlined the personal actions she felt she needed to take with regards to diet, to remain healthy:

I know that I love sweet foods, but they don't love me, so I'm aware all the time of what goes into my mouth. I know that if I want to feel good about myself physically I need to exercise, I need to drink water, I need to eat good foods...The physical side of my health...I've become really aware of where my food is coming from, what I am choosing to eat, how I am preparing it, and I've come to realise that some foods make me feel much better than other foods...

However, like other participants, Hilja understood that diet alone could not avoid all illness in life: "I know I am in charge of a lot of things in myself, but am I in charge of not ever getting cancer because I choose not to, because I eat good foods, because I rest?...I don't think so".

Like many other Gen2 participants, Jorma proposed himself to be healthy because he had a good diet, was able to exercise and was in a good mental state due to reasonably low levels of stress in his life. For Jaana, to be healthy one needed to achieve a balance of eating well, being fit, living in a healthy environment, and being happy. She also explained that in addition to having a healthy diet, it was important to understand if she had any food allergies because she understood that like the link between mental and physical health, there was a clear link between some foods and physical health. Like other participants across all three generations, Jaana felt that moderation in all things including food intake was important for good health.

6.5. Food as an Arousing Subject

The first generation, in particular, appear positively aroused by food, rather than indifferent, and food appeared in their narratives as a symbol of their identity as Finns. For the participants who identified as Lutherans, the relationship with food may have been thought of as having a spiritual dimension.

Evangelical Lutherans believe that the bread and wine of Holy Communion is supernaturally transformed into the body and blood of Christ and that through consumption believers are: “...forgiven, strengthened in the faith in God, and empowered to love and serve our neighbours” (The Evangelical Church of Finland, 2010). Reflected in their narratives, Finnish food and the rituals associated with it, appear to have similar qualities in that food is thought to strengthen and empower them.

Continuing celebratory traditions with Finnish food kept Gen1 connected to the remembered ideal of the home country. Mikko put it this way: “ah I like Finnish food, sometimes New Zealand food is good too, but sometimes you get something Finnish one...you feel like you home”. Between the time I interviewed Niilo and writing my thesis, he passed away, making it even more special to have had the opportunity to spend time talking with him. Kaarina told me that a few days before his death she had been visiting Niilo and he had been in some pain and unable to eat. Niilo had told Kaarina that he could not eat anything, but that he had a feeling that he would like to have some pulla³¹, because it reminded him of home, illustrating the strong connection between food, identity and belonging in the migrant context. Kaarina agreed to bring some in for him the next day. As Kaarina was leaving Niilo shook her hand and said “you are my friend Kaarina” and she said “yes, and you are mine”. The next day he was taken by ambulance to hospital and later died, never getting his final taste of home. Lepää rauhassa³² Niilo.

Helvi, Niilo’s wife, recalled going back to Finland for the first time 17 years after migration, and how she gorged on the Finnish food she could not get in New Zealand. During the narrative she was almost enraptured with the memories, closing her eyes as she remembered the tastes and smells on her return to Finland:

Kerrie: What was that first trip back like?

Helvi: Oh it was lovely, it was wonderful, I just walked around everything,
and I oh it was unbelievable. I bought a lot of Fazer lollies like that,

31 Traditional Finnish coffee bread

32 Rest in Peace

the jam ones, the marmalade, and you could cut them in half, and stand on the street, and lean on the house, and eat one after the other. And next one was uuton-juusto, which is a goat's milk cheese. I would buy that much, and I would stand on the street, my poor sister-in-law was so embarrassed. And all the food...the food I must say is different, it was different, it was marvellous.

The pantheistic aspect of Finnish religion could also have had an influence on conceptions of food through the affinity that Finns have with the natural world, a world which is regarded as the true home of the Finn. Finland's landscape is one of vast forests, lakes and Europe's largest archipelago, and wild mushrooms and berries are essential elements of the Finnish diet (Encyclopædia Britannica Online; Solsten & Meditz, 1988; Visit Finland). Through her narrative below, Inkeri's identity as a Gen1 Finn is dramaturgically realised and presented as she remembered experiences with food, including the seasonal rituals of berry picking. She brings her narrative to a dramatic conclusion, by describing one particular memory of berry picking with her brother, where she felt so contented that she would have happily died then and there. This illustrates her deep connection to the rituals associated with collecting food from nature in Finland, and her deep happiness in being able to perform and remember those rituals as a revelation of her Finnish identity. Her narrative, which emerged as one continuous utterance, was in response to the last question in our interview, illustrating the importance of food to her experiences in the contexts of migration and health:

Kerrie: The last question is,
is there anything else you can think of that you want to tell me?

Inkeri: [Inkeri introduces the subject of her narrative, highlighting the importance of food by taking the final opportunity in the interview to talk about it again]
About that food that we were talking about.

[She lets me know that traditional practices around food in Finland continue to the present day, and how special they are because the ingredients from nature,

i.e., Finnish wild berries and fish, are not available in the same way in New Zealand]

The North Finland they still carry on the same practices,
and same food.

And every time I been in Finland they tried to make something that I was not able to have here in New Zealand,

like fresh water fish fried in the frying pan,

silakka.

They [are a] group of herrings family,

but they not herrings.

And of course lots of other things that they carry on really.

And course what we miss here too is the berry picking.

Because in Finland,

North particularly,

there is not many fruits growing at all.

[She reveals the seasonal ritual of collecting berries from the wild, reinforcing the unique and health-giving qualities of the food and the experience]

But we go berry picking in the autumn.

Firstly in the spring,

we go to swamps to pick up cranberries that have survived winter.

And then the summer,

late summer,

the same things the swamps grow cloudberry,

which is yellow juicy berry.

And it's in so few places that it grows that it's only made into liqueur in Finland.

And towards the end of July,

we go to blueberry picking

and we pick the blueberries and preserve them in the bottles and jars for winter.

And then the bilberry,

the lingonberry it is in Swedish,

red berry,

and that is so rich in vitamin C that you only smash it in the wooden drum,

container,

and put it outside and it [is] frozen and you don't need to preserve it,

it is so rich in vitamin C.

So the nature provides for that kind of things that in Southern Hemisphere people are enjoying from the fruits and things.

So yes those are the things I remember.

[Now the facts have been outlined, she brings the story to its dramatic conclusion]

The last,

not this last trip but trip before last,

I went berry picking with my brother and we had buckets full of lingonberries,

Red beautiful juicy lingonberries.

And it is so lovely on the dry autumn day because the lingonberries grow on the dry ground,

blueberries need a bit of moist,

but lingonberries are growing on a grey curly moss.

And I felt so happy picking lingonberries one autumn day,
that I looked and I was ready to die there because I was that happy.

[She sums up what she has told me, reinforcing that there are certain memories and experiences of food unique to Finland, and how they represent her unique identity as a Finn]

So those kind of experiences you haven't,
you don't have in New Zealand.

Yes.

Inkeri remembered food shortages as one of the hardships of war, and related these food shortages to health problems she experienced later in life. Her following narrative is performative and includes: various compelling characters such as wounded soldiers and her hungry four year old brother; evocative scenes like Inkeri walking tired and hungry over the bridge at midnight; and presentation effects like when she nearly cried herself when recounting the heartache of her mother not being able to feed her little brother because they had no bread. Through this animated account, Inkeri performs an evocative narrative, bringing together her remembered experiences of war and health, through the powerful symbol of food:

...but the whole life itself hasn't delivered a proper condition to live a normal life. And that is one thing that I been suffering most because my age group [born] 1926 to 1928 to 30 even, we were the ones who suffered most because of the war in Finland. And they were very abnormal circumstances. For instance, the schools, there was no schools. All the schools were taken for the Red Cross centres, for the hospitals for wounded soldiers. All the teachers were called in the line, Finland has the real struggle. And because of the war the northern part of Finland, because we had no farming industry as such, agriculture was further south, we were short of food, we had to go hungry. The whole [of] Finland had to be worked, operated by women and teenagers, because the men were fighting for the country, and the portions of the cards that we had for food were so small that I can remember a time when I walked back from the Mill after midnight shift I slept in my walk, when I had to cross the river over the hanging bridge, and I thought that if I

ever get to the time and the position that I can have food, all I'm going to have is milk and luncheon sausage – I was that hungry, oh I was hungry.

Yes...there are such a sad stories, I could almost cry. When my 4 year old brother asked Mum to make him a sandwich because he was hungry, and Mum had to say “darling I haven't got the bread”...And we were old enough to start working. I had to start my working life at 16 years of age in the Mill where I was lifting pulp from the machine. Doing mans' work – and that's why I ruined my body and that's the reason I couldn't have a family. Lifting too heavy things and doing it without food. It was terrible. That's why I can't even watch war in the TV, it gives me shivers and gives me nightmares. So. I know what the war is.

6.6. Summary

This chapter found that the notion of Finnish food created in the migrant context serves as a key symbol in the participants' 'cultural toolkit' (Gregg & Saha, 2006b) that is used differently by all three generations to construct a sense of identity and belonging. Understandings about food also contributed to the participants' conceptions of health across the generations. In this way, food can be thought of as a form of capital that is both accumulated and transmitted between generations, through the subtle teachings of the seemingly mundane everyday embodied food experiences (Bourdieu, 1989, 1990b). Habitus is enabled by this 'food capital' and therefore the participants' conscious and unconscious experience of food influences their dispositions to think, feel and act in the fields of migration and health across generations. Building on the theoretical notion of habitus that the social experiences of policy, migration and food can influence how the participants' think, feel and act, the idea that health keeping practices are influenced by these histories and the patterns of everyday life, is further developed in the next chapter.

Chapter 7. Models of Health Keeping in Everyday Life

“..... on pidettävä huolta terveydestä sekä harjoitettava kohtuullisia ruumiinliikkeitä, käyttäen vain niin paljon ruokaa ja juomaa, että voimat virkistyvät siitä eivätkä herpaannu. Mutta pidettäköön huolta paitsi ruumiista vielä paljoka enemmän hengestä ja mielestä! Sillä nämäkin kuluvat loppuun vanhuudesta, ellei ikäänkuin valeta öljyä lamppuun” Marcus Tullius Cicero (106 e.Kr. – 43 e.Kr.):Vanhuudesta.

“We must look after our health, use moderate exercise, take just enough food and drink to recruit, but not to overload, our strength. Nor is it the body alone that must be supported, but the intellect and soul much more. For they are like lamps: unless you feed them with oil, they too go out from old age” Marcus Tullius Cicero (106 B.C. - 43 B.C.):Old age, quoted in Sulander (2005, p. 3)

I did not expect to uncover a precise lay model of health, as articulated by Cicero over 2000 years previously (see above quote), among my participants. Through their ‘corpus of stories’, I did, however, uncover a conceptual lay model of health which all three generations used to explain health maintenance, and the reasons for good and ill-health. Their lay models influenced whether or not they sought health care and in what circumstances, the kind of care they sought and their approach to compliance with medical advice. Participant stories revealed how they have acquired collectively held common-sense patterns of thinking and acting over generations, and how these patterns are influenced by their histories and experiences, as well as public meta-narratives about health, gendered behaviour, and expressions of personal understandings about health. Narratives also revealed the complex, dynamic and multidimensional nature of health which defies reductionist categorisation. This chapter continues to build the multigenerational narrative of the study within the key theoretical construct of habitus, as well as delivering on two of the objectives of the thesis by investigating health experiences across generations.

7.1. Environment

All three generations considered the environment a factor in their health. Of particular note was the impact of cold weather on migration decisions and conceptions of health, and this is explored in the next chapter. Aside from the influence of cold, Gen1 mostly conceived of the environment through their war experiences and through working and living in Kawerau. Gen1.5 considered the environment in similar ways, with the exception of the war experiences which, given their age, they would have had

little experience of first hand. By Gen2, the environment was conceived more generically, and included an emotional aspect. The notion of environmental factors impacting health has some similarities to the environmental model of health (Larson, 1999), which has a focus on the ability of the individual to adapt to all aspects of the environment including the physical, emotional and social. Health is achieved, in this model, when the individual is successful in adapting to their environmental circumstances.

For Gen1, their experiences in a wartime environment had an influence on their model of health, and the view appeared gendered. The male participants reflected on the war as positive in terms of health, and they recalled a time when they felt young, fit and vital. For example, Niilo conveyed that:

...even war did not do any harm to me, no. I been this four years, I can't say that did anything wrong with my health. Maybe after officer's school, I think I had better health than before I went, because that was six months going all the time. Night and day, and that was quite good.

For women, wartime brought greater hardships. Inkeri related her health problems to the conditions she experienced during the war. For her generation, war meant a lack of schooling, lack of food, and women doing hard physical work while the men fought to preserve Finland's independence. She recounted having to do physical work in her teenage years with very little food, and linked these experiences to a lack of bone strength, resulting in some physical weakness throughout her life, saying: "...not only that I had to work hard on my teenager years just when the body would have been built, the big strong bones, and we did not have food to build them up with" and:

I had to start my working life at 16 years of age in the mill where I was lifting pulp from the machine. Doing men's work – and that's why I ruined my body, and that's the reason I couldn't have a family. Lifting too heavy things, and doing it without food. It was terrible.

There is a moral aspect to this narrative, revealing Inkeri's thoughts that illness in the future can result from physical actions in the past. A moral aspect to health is evidenced in a number of the participants' narratives. This could have been influenced by both Finnish and New Zealand public health campaigns that were based on the premise that unhealthy personal behaviours result in ill health (or 'healthism' as previously discussed). It could also have been influenced by having socio-economic control, through access to economic capital, over their lives and accepting responsibility for ill health causation, as opposed to groups that perceive themselves as socially and economically powerless victims of circumstances over which they have no control, and feel little responsibility. There are also

connotations of powerlessness, injustice, and impoverishment, as she described a time in her life when circumstances were difficult and outside of her control.

Many of the Gen1 participants lived and worked in mill towns, both in Finland, and then in Kawerau. For the men in particular, the work environment had an influence on their health. Niilo, like the other Finnish menfolk, was focused on hard work and their jobs, relating health and happiness to their ability to work and earn a good living for their family. Being able to earn a good living was one of the reasons the migrants chose to stay in New Zealand. When I asked Niilo if he thought he would have had a better life in Finland he responded “Difficult to say. But that depends only if you had work”. The Finns were well known in Kawerau for their work ethic and this may have stemmed from being raised in a country that was at the time relatively poor, with a harsh climate, and in a state of war. As discussed in Chapter Four, the Finnish welfare system was in its infancy when Gen1 emigrated and as adolescents and young adults they had struggled economically in an effort to rebuild their country post-war. There was no welfare safety net. Sakari summed up the situation when he said: “In Finland [it has] always been imperative that every individual has to carry his pack, otherwise out you go”. This shed light on why Gen1 put such a high premium on being able to work, keeping healthy so as to keep working, and on individual responsibility. This work imperative informed both their decision to emigrate, and also their view that being healthy is equal to being able to work.

While they acknowledged some questions surrounding the issue of Tasman environmental pollution, most were reluctant to make a firm connection between their employer, pollution and health. The notion that some subjects were considered too ‘hush hush’ to talk about is further explored in the next chapter. Gen1 adapted to their circumstances by keeping out of the areas of the Mill they felt were bad for health. Kaarina conveyed that her allergies resulted from living in the Kawerau environment with the combination of pollen from the pine trees and the pollution surrounding the Mill:

I know that the pollen, not just pollen from the trees that are around us, which most of them used to go to Tasman Mill anyway, because they were pine trees which are very bad with the pollen...So I never had allergy in my life up to 30 years, but when we came here I started to get allergy, all kinds of allergies. So I think that it's the, but I never lived so close to mill either, so I have a feeling that that has something to do with it – surroundings of the forest and the mill together.

Like Gen1, Rauno (Gen1.5) tried to keep himself out of certain areas in the Mill that he thought would have been bad for his health. He suspected that despite his efforts, he had been exposed to environmental dangers and suspected that it was his good genes that had protected him. It is possible that part of the reason for the good health of the Gen1 and 1.5 men who worked at Tasman was as a result of the regular screening visits to the mill doctor. In the early years, a requirement of working at Tasman was regular screening, including full blood count, cholesterol, blood pressure, weight, sight and hearing. Over successive years of cutbacks, the screening became less comprehensive and was no longer compulsory. However, for many who worked at the mill, screening became an important part of their health routine and a way to monitor changes in their health over their working lives and beyond. For example, my husband is able to access almost 30 years of screening results from his days as an apprentice at Tasman right through to his present day screening at Tasman. These results inform the way he thinks about this health, and also the actions he takes and what course of treatment is recommended by his GP. The only screening gap in his records is the times he did not work at Tasman. Tasman also provided him and his family with paid private health insurance. Despite cutbacks over successive years, Tasman has provided for the health needs of their employees in one way or another since the 1950s.

Gen1.5 acknowledged that environment could impact their personal health. For example, Rachel conveyed she was subject to both the blessings and risks of the natural world in which she lived:

...I would believe that first and foremost what is happening to me is because I am a part of the world, with its environmental issues, and its heavy metal issues, and viral issues, bacterial issues. And that's a part of the world in which I live, and therefore I am a part of that world. I am subject to both the blessings of clean air, and the curses of polluted air, so I don't see myself as standing above that or beyond that – I am part of that.

Like the Gen1 men, the 1.5 men equated the ability to work (paid or unpaid) with good health. Einari's narrative reflected this, and also reflected the primacy of physical health in his conceptions of health:

Kerrie Even though you've got this on-going heart issue, do you consider yourself healthy?

Einari Yeah. Yeah. I haven't really changed my lifestyle, I mean like you see some of the work that I've been doing around the place, I mean I mix concrete in a wheelbarrow and I'm still doing all sorts of carpentry work. I've insulated the

underside of the house, I've repainted and whole roof with a brush and like you saw presently I'm doing the shower. So I'm actually doing all those normal carpentry trade type jobs, I haven't slowed down at all in that light.

Environmental factors, both physical and emotional, could influence personal health, according to Gen2. Jaana thought that to be healthy one needed to achieve a balance of eating well, being fit, living in a healthy environment, and being happy. Mirja conveyed that a "stable environment" was important for good health. Linda had experienced some illness in her life and told me she felt "pretty lucky" to have been so well for most of her life. She put this luck down to having a good diet, as well as living in a good environment with good quality housing, and not being routinely exposed to sick people. Reflecting on the mental illness of a close family member, Linda considered that living in a healthy and emotionally stable environment could counteract some genetic illnesses, and may even prevent some genetic mental illnesses from being triggered. However, she viewed the issue as complex, and even if people did all the right things and lived in a good environment, illness could result because people can't: "...live in a bubble".

7.2. Physical Habits of Life

For Gen1, physical habits of life for good health included: hygiene practices, the exercise they took and their diet. Sauna, as an aspect of hygiene, was important for cleanliness and family ritual pre-emigration, and important for social/community ritual post-emigration (further discussed in the next chapter). Habits of life were largely developed in childhood, according to Gen1, and influenced by childhood according to Gen1.5. Childhood did not emerge as a theme for Gen2. Gen1 and 1.5 both reported their habits of health as exercise and diet, but no theme regarding hygiene emerged. By Gen1.5 sauna was only mentioned in reference to the social aspect, or as a tradition. By Gen2, only one participant talked about sauna and described it as being important for cleanliness, and as a tradition. This supports an argument that the pre-emigration Finnish health policy environment with its focus on hygiene, as discussed in Chapter Four, was an influencing factor on the health conceptions of Gen1, as was the availability and common usage of sauna in Finland pre-emigration. The notion that physical habits affect health has some similarities with the literature that finds good (normative) health behaviour correlates with good overall health:

[actions]...such as exercise, eating well, and adherence to medical regimens, tend to promote health and prevent illness, whereas others, such as smoking, excessive weight gain, and substance

abuse, can undermine health. The importance of health behaviour for overall health is undisputed...(Umberson, Crosnoe, & Reczek, 2010, p. 140)

7.2.1. Childhood: Nuorena vitsa Väännettävä³³

Gen1 proposed that their foundations for health came partly from childhood experiences. This view reflected Christensen's assertion that: "...lifestyles regarding body formation, physical activity and food tastes are transmitted from parents to children who will reproduce their parents' behaviour" (Christensen, 2011, p. 470) and Bourdieu's concept that dispositions are inculcated from infancy (Bourdieu, 1990b). Gen1 proposed that in childhood the structure of their body and mind was developed and this set them up for life. They conveyed through their narratives that the physical habits of life were also set down in childhood; even though they could change these as they got older and learnt more about what was required for healthy living. This reflected Bourdieu's notion that habitus is not static, and dispositions can be changed (Wacquant, 2004). Gen1 held they had a significant advantage in life if their parents had taught them good healthy habits in childhood. This conception of health was also reflected in their migration decision to stay in New Zealand, as discussed in Chapter Five, because they felt this would offer their children the best possible childhood, setting them up for a healthy and happy life. Inkeri conveyed her thoughts about the importance of childhood:

Health is the greatest gift of life, we only learn to appreciate its real value in the later years of life when we have lost some of it. And yet, we inherit the foundation for it from our parents in their genes even before our birth. I like to express here the blessing of a good harmonious and loving home and the parents, the way the parents bring us up, nurses and cares in us our growing years in which we form the habits for the whole way of life, habits of eating, habits of hygiene and habits of all the good things in life.

The focus on childhood could have partly been the result of the influencing Finnish policy on the health of mothers and babies as discussed in Chapter Four, and also partly due to Finns traditionally holding the nuclear family as very dear due to their view that small family groups needed to stick closely together in order to survive the harsh Finnish conditions, particularly in the North of the country. Some, like Kaarina and Helvi, had difficult childhoods as a result of being orphaned. For them, giving their children the good childhood they never had was an important aspect of their lives. Inkeri remembered a childhood where the mill her father worked for looked after its employees and their

³³ A Finnish saying told to me meaning that while you are a young the vine has to be bent i.e., habits and traits need to be taught at a young age, risks need to be taken at a young age in order to learn.

families – a theme that would be echoed in her adult life in New Zealand, illustrating how employers contributed capital to the lives of the migrants both pre and post migration. The mill in Finland provided a communal sauna, as well as a hospital for workers and their families where both dental and general health care were provided. Her siblings were born in the mill hospital and she remembered that: "...we were really looked after by the company that employed our father". In Finland when she was a child, there was a strong public health ethos and emphasis on hygiene. In the town where she lived with her family there were sanatoria to treat various infectious epidemics such as TB, scarlet fever, diphtheria and smallpox, and she recalled being vaccinated as a child before she started school at seven years of age.

A number of Gen1.5 also equated childhood with lifelong health. For example, Eino said: "I think upbringing has got quite a lot to do with your health as well, what you eat and exercise, sports, all that sort of stuff". Rachel also judged that her good adult health stemmed from her childhood, which gave her a foundation for emotional and spiritual health:

...had I not had a good physical upbringing, had I not had the nutrition that I needed, had I not had the exercise that I needed, had I not grown up healthy, I may well have been a less healthy person emotionally prior to my spiritual experience so I think it is very tied. I would give it a high rating...

Childhood did not feature as a factor for health for Gen2, perhaps as a result of having benefited from a 'taken for granted' healthy and happy childhood provided by their parents as a result of the migration decisions of previous generations.

7.2.2. Hygiene: Puhtaus on Puoli Ruokaa³⁴

For Gen1 the concept of hygiene was important for good health, and this was likely the result of being raised in the context of a health system that was based on hygienic thinking and focussed on the eradication of communicable disease, as discussed in Chapter Four. While hygiene did not emerge as a key theme for the health of Gen1.5 or 2, there is evidence of the persistence of sauna as a cultural symbol, as well as ritual/social cleaning traditions.

³⁴ A Finnish saying told to me is that cleanliness is half the nourishment.

Gen1 held it was important to keep themselves and their surroundings clean, and to avoid contact with viruses and bacteria. The lay theory that illness comes from the natural world is evident in the understanding that illness can come from infections caused by germs, and environmental elements such as the cold (Helman, 2007). This theory is also evident in the understanding that evacuation of abnormal illness-causing matter can be accomplished through sweating in the sauna. Regular access to sauna was considered important, particularly in Finland, for keeping clean and for killing bacteria and germs. It also allowed for toxins to exit the body via sweat coming out through the skin. Taking sauna for health purposes is reflected in the Finnish saying "Sauna on köyhän apteekki", meaning that the sauna is the poor man's pharmacy. Inkeri remembered that:

...particularly up in Lapland and northern part of Finland, where it was so cold that in the wintertime, there was no facilities to have a proper wash because we did not have running water in the house and sauna was the only thing that kept us Finns healthy.

In the 1950s when the Finns emigrated, sauna was still the main way to keep the body clean, particularly in some northern areas of Finland where there was no running water. When Gen1 arrived in New Zealand they discovered they could be clean without sauna, because they had plentiful access to hot running water, and also because the warmer climate meant that dirt and toxins in the body could be sweated out of the pores during the normal course of life, as opposed to having to create that sweating from heat in the sauna like they had to living in a cold climate. For example, Sakari reflected:

...hygiene is naturally again part of that good health. That's where Finnish sauna comes in...I came to conclusion [that] sauna on hygiene and relaxing purposes belongs to cold climate. Which means that your pores and the skin opened and you come clean this way. When we came here this was hot area at that time, so one did not need that. Simple test – in Finland, it doesn't matter how often, three four times sauna per week, but when you check your neck and put the white collar it's definitely brown after few hours use. Here, even no sauna, it does not get dirty any more. So, people sweat that much here that they skin clean out. I don't say that I don't need sauna, it probably should be very good for me, but have to cope without.

Underlying the sauna tradition was the Finnish religious belief in the health-giving aspect of heat and steam, which is explored in the next chapter. Continuing to use sauna in New Zealand was more about the continuation of tradition; relaxing and engaging in a communal activity with other Finns which was a practice of their identity, and distinguished them as 'exotic' in the town of Kawerau. Inkeri commented: "...it's a treat, but you can be healthy without".

Like many others in her generation, for Inkeri, taking steps to reduce exposure to germs was important for good health:

...hygiene is the most important thing. I remember when my God-daughter that used to stay with me after school every day, every time there was some virus or bacteria going on in the school, particularly New Zealanders the way they are so friendly they hug and kiss everybody. I got germs, I got everything that was going in the school. But yes that's one thing that you can be careful, and you try to avoid to get contact with people that are sick.

Inkeri also revealed that her family's concern with hygiene was connected with endemic tuberculosis which had affected her family, and she thought her current health problem resulted from a "family weakness of the lungs", as well as her exposure to cigarette smoke in her work-life in New Zealand.

I observed that clean surroundings were important to the Finns and associated with hygiene, as well as a being important as a ritual and social family tradition. Cleaning processes, and the result, was a source of pride, much like Finnish baking and cooking. While hygiene did not emerge as a key theme for health from Gen1.5 and 2, the ritual and social aspect of cleaning taught by Gen1 appeared to persist. Every participant home I went to was immaculate, both tidy and clean. My Mummu had taught my Mum, me and my children, how to clean "properly", and special rituals of cleaning were planned in preparation for events in the year such as Christmas, Easter, birthdays or people visiting. We started the "Christmas cleaning" in November and this included washing mats, a wipe down inside all cupboards, ceilings and windows, in addition to the usual thorough clean. We often helped each other with this to make sure that all our houses were ready for Christmas and other important occasions – it was a social event and was often discussed within the wider Finnish Community. The cleaning practices stemmed from seasonal traditions in Finland, were brought to New Zealand with Gen1, and appeared to persist in New Zealand despite the change in seasons from the Northern to the Southern hemisphere.



Figure 20 Communal Lakeside Finnish Rug Washing Station (2008)

Most of Gen1.5 did not talk about sauna, but of the few that did, it was in the context of keeping cultural traditions. Hilja recalled:

We would go to sauna on Christmas Eve, you know sauna would be going down by the river all day, and families would go for just say shortened half hour slots so all the families could get in, because no one had private home saunas at that point which they do now.

Hygiene did not emerge as a key theme for Gen2. However, Maire, like her father Einari, felt sauna was important for cleanliness as well as emotional health through being able to make a connection to self through the sauna tradition. Maire told me she felt strongly connected to her Finnish heritage and that keeping the connections to her Finnish heritage, such as going to sauna, contributed positively to her health because: “I think it’s important to me to see myself as a whole person, to keep that connection to Finland strong”.

7.2.3. Exercise

Exercise was important for both the body and the mind, according to Gen1. For Gen1.5 exercise was important for the body, but there was less emphasis on the impact of exercise on mental health and more emphasis on exercise as one way to counter the negative impact of genetics. The Gen2 view of exercise was similar to Gen1, conveying that exercise was beneficial for both mental and physical health. All three generations talked about good diet and exercise going together, noting a balance of both was needed for good health.

When asked about what is important for good health, Kaarina (Gen1) responded: “For me, I go for my walk in the morning which clears even more the mind and get good exercise,” and: “...if you try to eat well, exercise, and look after yourself, then you will most probably be healthy for a long time”. Niilo told me that to be healthy you: “...must walk, you must go outside, outside air”. He developed a heart condition later in life and could not understand why, as he was very sporty when he was younger, even being placed third in a Finnish national competition for athletics. He concluded that his heart condition had developed later in life when he was not exercising as much and gained a lot of weight, particularly when his wife got pregnant – he joked it was perhaps an empathetic weight gain!

Aino (Gen1.5) proposed that exercise had helped her counter the negative impact of her genetic heritage, as she was the now the oldest living family member of two generations. Her narrative revealed a moral aspect. She explained that the difference between her and her family who died from heart disease was her personal decision to take action regarding her diet and exercise:

Well, having family with the real serious heart problem in our family, Mum died of heart, Dad died of heart, my brother has died of heart...I was about 40, I decided I'm not going to die early of a heart attack so I got a real fitness freak...started running marathons and running marathons and just decided to keep in healthy exercising and eating well.

Hilja (Gen1.5) told me she kept the “Finnish curse” of high cholesterol and blood pressure at bay through good diet and exercise, and also considered that good sleep was important for the body (in contrast to some of Gen1 who described sleep as important for the mind). Her narrative also revealed a moral aspect, as she equated being healthy with the personal actions she took:

I know that if I want to feel good about myself physically I need to exercise, I need to drink water, I need to eat good foods. I know that I need sleep so I try to sleep as much as my body needs me to. I don't stay up late at night and then get up early in the morning.

Like previous generations, the combination of diet and exercise were prominent in Gen2's concept of health. Linda viewed health as a blend of mental and physical well-being and felt that if she was fit and not feeling sick, then she was healthy. Diane also strongly equated being healthy with being fit and eating a balanced diet. Jaana suggested that to be healthy one needed to achieve a balance of eating well, being fit, living in a healthy environment, and being happy. Like many other participants, Jaana

explained that stress or emotional issues could manifest in physical symptoms and so it was important to maintain good mental health. One way she did this was through physical exercise. She felt she could be more healthy if she exercised more, and that when she was very fit she felt: “on top of the world – energetic and amazing!”

7.3. Non-Physical Dimensions of Health

All three generations conceived of health as including both physical and non-physical aspects, which has some similarities with the model described by the World Health Organisation (WHO) definition of health as: “...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organisation, 1946). This conceptualisation has a focus on physical and mental health, with its roots in the scientific paradigm where the body is viewed as machine-like (Larson, 1999). Gen1 understood health to include a mental component as well as physical and that mental and physical health were related. Reinforcing Gen1’s optimistic disposition was the view that in order to be considered healthy, a person must have a happy and clear mind. Having a number of non-physical aspects of life in balance formed Gen1.5 and 2’s conception of health and included: mental, emotional, spiritual aspects, as well as the importance of managing stress and keeping good family and social relationships.

Sakari (Gen1) described what it meant to him to be healthy:

This is a feeling in the morning am I healthy, am I okay, mentally and physically. Means am I happy – I have to be healthy if I am happy and don’t feel any pain...Naturally mental part there, psychological part, happy mind - healthy life.

Kaarina felt getting good sleep contributed to good mental health which in turn supported good physical health:

I get up in the morning feeling good because I have good night’s sleep and then good enough to start the day’s work with a happy mood, and that’s how I think that I am healthy...if you have had good sleep, your mind is clear.

She also proposed that her state of mental health could impact her physical health because: “...if you are feeling good then you feel like you want to do this and that and doing it gladly, instead of dragging yourself”.

Helvi illustrated her understanding that negative thoughts could affect health, through her recollection of an Easter experience in Finland:

I remember one year was Easter, and on the radio they lived through the whole Easter from Good Friday [the Passion of Christ], slowly and slowly what was happening – I was nearly going crazy, and there was nothing else on the radio. Because they told – it's a horrible story though Christians, we say it's not, you know – but for the person who is already kind of...it was at least 10 suicides that Easter who had been listening to that and had got so down and so depressed hearing of it.

Having a number of non-physical aspects of life in balance formed part of Gen1.5's lay model of health and included: mental, emotional, spiritual aspects, as well as the importance of managing stress and keeping good family and social relationships. Hilja's narrative also revealed a moral aspect to her conceptions of health, as she reflected on the personal actions she took to keep balance in her non-physical life:

For me health is a totally holistic thing. Health is not just about your body, I think health is about your mind, your emotions, your spirituality, your physical, your mental, emotional self. So it's a real holistic thing for me...I think it starts first of all with being aware of who you are and your needs. So I know that I have emotional needs that need to be met in certain ways so I seek out situations or people who can meet those needs for me...I think really what it is, is just being very sensible with myself and being attuned to what my needs are – emotional, and the holistic needs altogether, so I make sure that I surround myself with people who I feel cared for, cared for by. So that's sort of the non-physical side of my health.

She communicated that emotions affected physical health; if a person was feeling down emotionally, then they would not have the will to fight a physical issue, and conversely that:

At another time on the continuum they might be on a real high for some other reason, maybe they're...going out training for a marathon and nothing's going to get in their way short of a broken leg. And they may be exposed to the same amount of bugs and things and just not get sick because emotionally and mentally they're just willing themselves on.

Aino stated that a good outlook in life and low stress levels are needed for good health. She held that if she did not want to get sick, she would not get sick, due to her positive outlook in life. Rachel

understood that health was about: "...physical, spiritual, emotional wellbeing" and that a balance between these things was important. She went on to say: "...if you can maintain the balance then there is a greater likelihood of all three areas functioning well". However, because of her strong faith in God, she told me she would place spiritual health as a bit higher than the others. Rachel told me a story of her experiences with a long term health problem and explained how she would not have been able to walk through the hardships with a healthy outcome had she not been: "...pivoted in the spiritual". She conveyed that when her physical and emotional selves were depleted, her spiritual-self pulled her through and this allowed her to be emotionally and physically healed.

Einari described being healthy as having: "...a balanced lifestyle alright, that's what I would say. So you've got to have a family life, you've got to have a social life, and then you've got to have...like in my case sport was very very important, so that's the way that I would describe it". He conveyed that if any of those things were out of balance, illness could result. Einari also proposed that the mind affected the body and therefore if he could control his mind and reduce stress for example, he could positively impact his physical self.

Like Gen1.5, having a number of non-physical aspects of life in balance formed part of Gen2's lay model of health and included: mental and emotional wellbeing, lifelong learning, work, family, maintaining cultural connections, spirituality, enjoying life, and a low stress environment. They conveyed in their interviews that when these aspects were out of balance, illness could result. Carl conceived of health as personal wellbeing, encompassing mental health as well as physical functionality. He proposed that mental health could affect physical health, for example stress and pressure could manifest itself as a back injury. This notion is similar to the wellness model of health which makes a link between the mind and the body, proposing that the mind can affect even the most basic of physical processes such as the digestion of food (Larson, 1999). Carl felt his competitive sporting activities and exercise had been good for both his physical and mental health. In addition, Carl looked after his mental health by engaging in lifelong learning and striving to achieve balance in his life between work and family. He proposed that if any of these aspects – diet, exercise, learning, family - were out of balance, mental or physical illness could result. He was also re-engaging with his cultural heritage from his non-Finnish father's side, and felt this was a contributor to his wellness.

Maire had a holistic view of health, including a balance of physical, emotional and mental wellbeing:

I think it's important to have a balance of all aspects...in terms of your physical, mental, emotional and spiritual...I do think it's important to have each of those areas kind of filled in your life...in my view if it's veering too much towards one or the other...if you are just focusing on the physical and you become a health nut and that's all you are actually doing then you are kind of missing out in my view of some of the other things in life and that to me is not a well-balanced kind of healthy way of living.

She said that “doing too much” in both family life and work caused stress, and that could make her susceptible to illness. At the time of interview Maire told me she felt healthy because:

...I feel good, I feel...comfortable in my own skin and I feel that...I am coping well in my life, and family, things are good at home...I'm happy with the way things are at the moment.

Jorma, Maire's brother, held himself to be healthy because he had a good diet, was able to exercise and was in a good mental state due to reasonably low levels of stress in his life. He told me that: “...the way you live and look after yourself” including achieving a balance of exercise, diet and good mental health would result in good health. Like other participants, Jorma said that exercise contributed to both good physical and mental health, and that stressful life circumstances could result in physical illness. Paul proposed he was healthy, and defined this as: feeling good, being reasonably fit, having no illnesses, having a reasonably good diet, and enjoying life. Like other participants, Paul explained that being “mentally happy” and “enjoying life” contributed to his good health.

7.4. Summary

Participants' models of health keeping in their everyday lives, and across the generations, were revealed in this chapter. Both Gen1 and 1.5 conceived of health as a balance of physical and non-physical aspects, each with the ability to impact the other. Physical factors included the environment, and habits of life such as diet and exercise, which were influenced by childhood experiences. In contrast to Gen1, hygiene did not emerge as a key theme for Gen1.5, but the traditions of sauna and house cleaning persisted. Non-physical aspects, and having these aspects in balance, formed an important part of Gen1.5's lay models of health and included: mental, emotional and spiritual aspects, as well as the importance of managing stress and keeping good family and social relationships. This was in contrast to Gen1's more narrow focus on mental health. Gen2 conceived of good health as achieving a balance or moderation of a number of inter-related, and sometimes causal, factors. Physical factors included having a good diet, regular exercise, sauna, access to medical services when

needed, and living in a healthy physical and emotional environment. Non-physical factors included having a good attitude, the benefits of exercise on mental well-being, fulfilling family relationships, a learning environment, maintaining cultural connections including taking sauna, emotional well-being, a spiritual connection, a low-stress environment, being happy and enjoying life, living in a healthy environment, and feeling self to be healthy despite having diagnosed conditions. Having a balance of these physical and non-physical factors, and approaching life with moderation in mind, was assumed to result in mental well-being and an absence of the physical symptoms of illness. Unlike the previous two generations, having a good childhood and hygiene did not emerge as key themes for Gen2; perhaps as a result of taking this for granted.

The generational lay model of health described in this chapter demonstrates how narrative can reveal patterns of thinking and acting about health which do not necessarily reflect established policy definitions or models of health. For example, there is a naturalistic expectation across all three generations that disease can be controlled, and therefore help should be sought from medical science (Lupton, 2003), and that concrete explanations for illness can be found (Swami et al., 2009), as well as an understanding that health is broader than the biological, and includes aspects of spirituality and the idea of balance. Religious, spiritual and supernatural components, more often seen in Pacific, Asian and African cultures, are also evident and discussed in the next chapter. The chapter also described how some patterns of thinking and acting with regards to health are collectively held and aspects are passed between generations, allowing the potential for change and adaptation as everyday patterns and practices are sedimented across generations, illustrating the usefulness of the theoretical construct of habitus for this study. The lay model described in this chapter, which included environmental as well as physical and non-physical aspects, is further expanded in the next chapter through stories of health and illness that reflect biographical and sociocultural experiences across the generations.

Chapter 8. Health Keeping Embedded in Social Experiences

Building on the previous chapters, this chapter reveals how health and illness narratives are more than a personal story of experience; they reflect wider life circumstances and experiences and how people make sense of these. This chapter explores the structures of social being, the foundations of knowledge and the hidden possibilities of history (Wacquant, 2006, pp. 261-277) that are revealed through narratives of migration and health where the biographical and sociocultural intertwine (Charmaz, 2006; Dorazio-Migilore et al., 2005). Through this deeper narrative exploration of habitus, the participants' complex, dynamic and multidimensional conceptualisations of health, which are deeply embedded within embodied social experiences, are revealed. The chapter also illustrates how the multiple data sources in this study can provide the variety of data required to produce a rich and thick 'portrait of a people'.

8.1. A Structuring Disposition

There is evidence across all three generations of a self-responsible, self-determined and optimistic disposition. These dispositions were indicated by how the participants made sense of their migration experiences as described in Chapter Five, and in the lay models of health outlined in the previous chapter. How the participants thought, felt and acted were reminiscent of the Finnish defining characteristic of 'sisu' (grit and guts), which was passed down from their ancestors, and developed through perseverance under harsh conditions, war and centuries of endurance under foreign masters (Encyclopædia Britannica Online; Solsten & Meditz, 1988; Visit Finland). Brown, Crawford, Nerlick & Koteyko (2008, p. 1048) proposed that:

The biographical and historical trajectory of an individual will predispose them to specific ways of perceiving, conceiving, reasoning and acting. This shapes tastes, desires and systems of morality in a manner which often escapes conscious attention.

This does not mean, however, that dispositions are deterministic; they are rather a generative principle, or a structuring disposition to think, feel and act (Bourdieu, 1990b; Hilgers, 2009).

8.1.1. Responsible and Determined - Oma Apu Paras Apu³⁵

A sense of self-responsibility and self-determination was evidenced in many areas including Gen1's attitude to knowledge, as well as actions taken when experiencing illness. They conveyed in their narratives a view that knowledge supported good choices in all things, including the decision to migrate and the health knowledge required to live a healthy life and to treat ailments. A number described how they could treat themselves, both by using family health knowledge, which came primarily from their mothers, and also modern health knowledge, which came from medical books and the internet. They made sure they kept their health knowledge up to date by educating themselves. If they could not treat themselves with family remedies, then they would go to the doctor, but they made sure they were fully informed, and did not just take what the doctor said as the truth without checking their own knowledge sources. This could, at times, reduce compliance with medical advice, including not taking prescribed medications or having recommended surgery.

For this generation, illness was generally not regarded as a random event (even though there was an acceptance that random events do occur); there was usually a cause attributed from choices they themselves made, or situations they found themselves in i.e., the war. Dealing with illness involved first finding the cause, and then taking the appropriate action to remedy it. A number of narratives evidenced a moral aspect ascribed to illness, with participants describing personal actions that should, or should not, be taken regarding health. Underlying these narratives was a sense of self-responsibility for actions, and subsequent blame if illness were to result i.e., eating the wrong foods resulting in a heart attack. This moral aspect was somehow reconciled with their understanding that genetics could influence health, particularly for Gen1 and 1.5.

Sakari's story illustrated Gen1's approach to dealing with illness. He remembered how his mother managed ailments and from my observations, he managed his health issues in much the same way, by first trying family remedies and also relying on his own health knowledge for diagnosis and treatment. Then, if needed, he would consult a doctor and take medications, once he had checked the diagnosis and prescription on the internet or in medical books. This disposition for self-responsibility and self-determination in health issues was reflected in Gen1's attitude to life which was influenced by their war experiences and their experience of living in Finland at a time when very little social welfare was available (as discussed in Chapters Four and Five). Sakari told me you must: "...carry your own pack", meaning you must take responsibility for yourself in all things and not rely on others or the

³⁵ A Finnish saying told to me meaning that one's own help is the best help.

government to help you. This illustrates the depth of analysis that results from multiple data sources; the interview comment “carry your own pack” was not explained by Sakari, but emerged as evidence of a disposition (*habitus*) when contextualised within a review of historical/policy/archival materials, narratives, observation and previous social interactions in my role as an ‘insider’. When I met with Sakari for our interview he had just had a bee sting which he treated with cortisone cream from a medical box of various items. He likened this to an old family remedy of spruce gum, butter and milk and suggested that this was probably similar to the cortisone he had just administered for his bee sting. Sakari reflected in the interview on his thoughts and actions about health knowledge and seeking treatment, commencing with a story about how his mother, who lived to 86 years of age, managed ill health. He then related this to his own approach to dealing with illness, conveyed in the following narrative excerpts:

...she went to doctor at least three, four times per year. I’m talking age of 60, 50 – 60 years age bracket. But she never did use those medicines. She said “ah that’s no good” and she threw them away. Any kind of bottles or any kind of mixtures from chemist, she did not take them. Her medicine was good cognac, vermouth and aspirin or that kind of headache pills, and home remedies...

Old saying like Finnish – “If sauna and terva (terva is tar, wood tar) does not help then the disease is for dying”...If there was a skin or wound or accident, that kind of thing, spruce gum was taken from forest and mixed with butter and milk and that was used like cream to heal wounds and boils and that kind of thing...Old ladies did know everything...

Nowadays...I usually give week or two first of all I try to find out what is wrong and then use my own [supplies] what might be in the medicine cupboard, or what I know I should do, waiting week or two if it’s not very clear to get over it. And often time will fix it, no reason to go to doctor...

Probably my background, my wife’s background, my family background, both our background – dying, dead, diseases, knowledge of those. So I probably because [of] my mother I have [been] born not entirely to trust medical profession. I don’t let my sickness to doctor “you deal with it, you see what I have done”. Over every country I believe people take a easy go out from their

wellbeing, they let doctor to decide. He will tell me what to do and I will be okay. My logic on this one is no, no that way...

We have information available in book form already at home, or internet, and we check every pill. They wider scale than any doctor have a time to tell or any pharmacy have time to print. Their side effects, duration, connection to other medicine, whole spectrum of best doctors' knowledge is available nowadays in people's hand if they want it to know... Reading, listening other people, reading information, information after information, and making calculated guess, calculated guess what it might be what it is not. Usually thinking individuals come rather close accurately [to] what is wrong. Naturally, internal organ diseases are not easy to establish sometimes, but 50/50 cases one can be rather sure what is wrong.

This narrative serves multiple purposes for Sakari: to remember admiringly his mother's approach to illness "Old ladies did know everything"; to justify his own approach to illness "I have [been] born not entirely to trust medical profession"; and to persuade "...I believe people take a easy go out from their wellbeing, they let doctor decide". In fulfilling these purposes, he spans the temporal horizon through his narrative, bringing together the past, the present and revealing how he would approach illness in the future. I felt this story was constructed also to instruct me in what I should do to live a long and healthy life like he had – taking the opportunity in the interview to share a life lesson from Gen1 to Gen2 through narrative. In this way, narrative is shown to be performative and contextual – it is delivered for a purpose, at this time, in an interaction with me. The narrative also reinforced a reoccurring moral theme for Gen1, that people should be personally responsible for their health.

Like Gen1, Gen1.5 also placed importance on being knowledgeable about health, and on their ability to make good choices about their health based on this knowledge. They had a pragmatic approach to medication, taking it only if necessary after considering other actions available to them, and within their own control to change. They would seek help from a doctor when needed, but would not give over total control to them. For example, Hilja stated she was 'anti-drugs' like her father Sakari, because in her view they interfered with the natural balance of the body. While medicating could help with one thing, she said it could put something else out of balance and so Hilja would try to manage her issues with diet and exercise before considering taking medication, even when recommended by a doctor. Again, illustrating the benefit of multiple data sources and 'insider' status, I have been able to

observe Hilja recently grapple with an increase in blood pressure. When recommended by her doctor to take medication she refused, choosing instead to adjust her diet, increase her cardiovascular exercise, and monitor any changes closely. Eino felt like many Gen1 and 1.5 when it came to going to the doctor. He would go but would not give over all control to the doctor: "...[at] the end of the day even the doctors don't know everything but they know much more than I would, so doctor would be the place to call, yeah".

Gen2 also evidenced a disposition for self-responsibility and self-determinism with regards to their health. They would not hesitate to seek medical assistance when needed, but would also take responsibility for their own actions in managing their health. For example, Fiona, in a similar approach to her mother Hilja and her grandfather Sakari, would take medication if she thought there was a direct correlation between the medication and her symptoms, but she felt that: "...there's a lot of people that probably don't need to be on medication that take medication for the hell of it even though their body could handle it on their own". Also like her mother and grandfather, in my observation of Fiona, she would consult a doctor when she felt it was necessary after attempting to treat the issue herself, but would not hand over total control to the doctor, preferring to check symptoms and any advice given on the internet first. Once she had done her research, including talking to family members about the issue, and taking into account the doctor's advice, she would make a decision about how to proceed. This illustrates the generational nature of habitus. Paul also believed in taking control of health problems, and not solely relying on doctors. This was illustrated in his approach to seeking help from doctors for the chronic condition of a close family member:

...researching what you can and can't do, a lot of the stuff you have to look into yourself...The doctors are there to help you as long as you go and see them, but apart from that you have got to do what you can to help yourself now...if we hadn't done a lot of that stuff ourselves things would not get done, we'd still be waiting so...

8.1.2. Optimistic - Toivossa on Hyvä Elää³⁶

There is evidence of an optimistic disposition in all three generations, revealed both through their migration experiences as discussed in Chapter Five, and through their lay conceptions of health described in the previous chapter. A high self-esteem, a sense of optimism, as well as good self-rated health has been associated with positive health behaviour and conversely, bad self-rated health, low

36 A Finnish saying told to me meaning it is good to live in hope, a hopeful person is a happy person

self-esteem and a negative disposition has been associated with negative health behaviour (Courtenay, 2003; Marks et al., 1999; Weinstein, 1982). Physicians and psychotherapists have for many years recognised the link between psychological and physical disorders, and: “There has been long recognition that an optimistic mind and exhilarated spirit accompany a healthy body” (Salovey et al., 2000, p. 117). This finding contributes to the theory on health behaviour discussed in Section 2.3 by illustrating the connection between mind and body – what people think about health can influence how they behave.

There was a sense of optimism and quiet pragmatism from Gen1 about health, despite some having faced significant health problems in their lives. This arguably stoic attitude could have reflected their pre-emigration policy environment as discussed in Chapter Four, where being healthy was considered part of nation-building activity – to be a Finn was to be healthy, not complain and to persevere in the face of adversity. Their optimistic disposition could also have reflected their religious beliefs, gaining strength from the acts of prayer and faith to enable them to cope with life’s hardships. This analysis again illustrates the benefits of multiple data sources in producing a highly nuanced ethnography.

For example, Kaarina considered herself healthy even though she had a serious heart condition for which she took medication and conveyed that: “Yes, I consider I am a healthy person if I don’t think about this problem with the heart, otherwise I am healthy.” Sakari considered himself healthy despite living with a degenerative and sometimes painful condition. In contrast, Inkeri and Helvi had health problems that caused them daily physical pain or impairment, despite taking medication. Inkeri thought of herself as a survivor, having lived through various serious illnesses in her life. Helvi had come to terms with her debilitating health condition and the impact on her mobility. She accepted that she had come to the end of her medical options and so she took her painkillers and tried as best she could to get on with her life. Aside from her health problem, which she called her “main evil thing” she felt healthy. This description reflects illness narratives where disease is referred to in impersonal terms like ‘it’ or ‘the disease’, indicating the disease is viewed as a separate ‘thing’ from the person. This ‘thing’ is often described in language which indicates the disease is an unwanted invading object which must be removed in order to restore bodily integrity (Frank, 1998).

Like Gen1, Gen 1.5 participants conveyed they were healthy because they could still do all the things they wanted to do; they optimistically continued to consider themselves healthy despite some

participants experiencing major health problems, or taking regular medications. For example, Katie, despite having been through a number of serious health issues, considered herself healthy because she had survived and was now well. When asked if she considered herself healthy, Katie replied: “On the whole yes, considering all I have been through”. Despite taking medications for a diagnosed condition, Aino considered herself healthy because:

...I’m perfectly fit, I’m still getting around doing all the stuff that I did 10 years ago. I guess, you know, you can’t be my age and have no aches and pains but I mean they no problem, nothing I can’t handle...

Gen2’s attitude to illness in their lives also reflected an optimistic disposition and a quest narrative. Despite personal illness, or the illness of close family members, they would focus on moving forward through the experience, taking any positive aspect from it that they could. They also considered themselves healthy even if they had health problems. For example, having been through serious health issues in her family, Diane’s view was that no matter what happened in the future, it would not “drag her down”. She would learn from the experience and become stronger. I had observed Paul over many years, including his reactions to dealing with the chronic illness in his family. His disposition for resilience and optimism was revealed through his narrative:

I just think it’s just the way that I am. I seem to be able to just get on with it. Even when the times are bad I can still carry on functioning, I don’t really get down...even when you know things have been pretty bad at some stages and you know it could be upsetting but it doesn’t get me...I don’t get depressed or anything like that, I just carry on.

8.2. Fate

The concept of fate, in some form, emerged as an influencing principle for most participants across the generations in the field of health. The way in which this was expressed followed a similar pattern to their religious affiliation across generations; the more religious (Gen1 and some 1.5) participants conceived of fate in terms of the Lutheran doctrine of pre-destination, and the less religious participants (some Gen1.5 and 2) conceived of fate in non-religious terms, such as destiny.

Almost all Gen1 identified as Lutheran, which reflected that in 1950s Finland 95 per cent of the population identified as Lutheran. Church traditions and policies would have been a significant

influence in their lives pre-emigration (Statistics Finland; Visit Finland). As described in Chapter Five, building a Lutheran Church in Kawerau was one of the early activities of the Finnish settler community, enabling them to carry on their church traditions in New Zealand. Many Gen1 explained the decision to migrate and live their lives in New Zealand as fate, a concept that has similarities with the Lutheran doctrine of predestination, being that all events are willed by God (The Evangelical Church of Finland, 2010). Another aspect of the Lutheran faith is that the: “Christian parish is a communion of grace. No one can do God’s will by his or her own power” (The Evangelical Church of Finland, 2010). Lutheran doctrine holds that Christ is present in the church through the Bible and the sacraments of baptism and Holy Communion and that the bread and wine is supernaturally transformed into the actual body and blood of Christ. Through this act believers are “forgiven, strengthened in the faith in God, and empowered to love and serve our neighbours” (The Evangelical Church of Finland, 2010).

Many Gen1 believed there was a spiritual component to life which could affect health, but that it could not directly affect them unless they wanted it to. While they felt largely in control of their lives, they felt that a spiritual belief could help them through the acts of believing and prayer, as opposed to an external intervention of a spiritual force. For this group, the act of praying helped strengthen them, giving them the fortitude to cope with misfortune, such as illness. Sakari believed that the act of prayer to God could remind him to be careful in all things and that this would help him stay healthy, but that cosmic or spiritual forces could not otherwise affect him. He reflected that: “...if one does not want anything to do with it, outside cosmic or whatever forces will not dictate...” To my question: “Do you mean it will only affect you if you want it to?” Sakari replied “That’s right, if one wants and believes for it. And works with it”. Inkeri’s view was representative of most of Gen1. She believed in God, but also proposed that people should use their God-given intelligence to seek health knowledge and care for themselves. In her view, evil in the world resulted in misfortune including ill health, and that while God listened to prayer, it was the acts of faith and prayer that strengthened her emotionally, not any direct intervention from God:

I believe in God with my whole heart, my whole soul, but there are lots of things that we can do with the knowledge of today to keep our health...I don’t think that God gives sickness...God is a loving God, he doesn’t punish people. He sent his own Son to die for our faults. Prayer can help people to change their beliefs, their mind. And that prayer is worthwhile always...it is one of the psychological things that helps people. They can help themselves in the way that they make themselves believe in better things. And so that then helps their health, yeah.

There was evidence of an aspect of predestination or fate with regards to mortality in the narratives of Gen1, with a stated belief that when your time is up, it is up, and there is nothing you can do about it. Kaarina remarked: “I believe that we all have been given certain time to live in this life, that’s my belief”. When asked who is it that gives us our time, she replied “God, because I believe in God”. She went on to say:

When I had this appendicitis operation and the doctor told me afterwards that “I almost lost you”, I asked him, “how come”, and he said “your appendix had gone round and round your intestines and it was only a very, very little time left”. So if he did not operate at that time it would have choked and that would have been my life gone...I believe that because there was many people praying for me at the time, and I cannot say, that I just feel that it was not my time. God always listens [to] prayers that’s my belief, and maybe that was the benefit [for] all of us, because I was sick, and the people who were praying. Maybe their belief in God got stronger because of that.

Kaarina’s narrative evidences aspects of what Frank (1998) describes as a quest story, where the illness experience is represented as a journey from which something useful can be learned. In this case, Kaarina proposed her illness had strengthened peoples’ lives for the better, through their acts of prayer for her recovery. Kaarina had another near death experience in 2011 as a result of her heart condition and in her account she reflected again a belief in predestination in that it was not her time; that is why the nurses and doctors were able to save her and why she was in the right place at the right time to get good medical care. Her story illustrates the temporal nature of narrative (Garro, 2003) discussed in Chapter Two; it provides an orderly structure through which Kaarina can construe her reality, linking her current heart ‘trouble’ with perceived pasts and/or possible futures within her framework of predestination. Through her narrative, Kaarina remembered how things have happened in the past, and links that remembered past to the present, exploring how this might shape her future.

Not all Gen1 believed there was a spiritual dimension to health. Mikko and his wife Aila did not believe that spiritual or cosmic forces could impact life or health. Mikko believed in the power of a positive mind and Aila believed that some people are born to have accidents or to be ill, that is their fate in life. Like other Gen1.5, Hilja understood there were some things that people could not escape, even if they made all the right choices:

...and that kind of comes from my spiritual understanding of fate or predestination or the fact that our lives are in the control of something outside of ourselves, and I haven’t really worked out exactly how much I am in power of me. I know I am in charge of a lot of things in myself, but

am I in charge of not ever getting cancer because I choose not to, because I eat good foods, because I rest? ...I don't think so.

She felt that people should do their best with their health and never give up, but if despite all efforts a person gets a disease like cancer, then they should pray for the strength to cope with it:

I think we can do the best that we can and we must and we must never give up and say "well what's the point". But then you know something might come and hit you, bite you in the bum, when you least expect it. So...I'm not smug about being healthy. I thank God that I'm healthy today. And I say please God if there is something around the corner that's going to be a really toughie, give me the strength to cope with it.

Rachel expressed that: "...in terms of health and the big picture I'm not in control of my health 100 per cent, I mean I'm not God". In contrast, Einari told me that the power to control or improve life events was within the individual and came from within themselves, as opposed to the influence of any external force. This was evidenced in his attitude to his major health problem where, despite doctors' advice to the contrary, he was determined to impact his heart problem by taking steps to reduce stress in his life.

There was very little evidence that Gen2's beliefs about life were informed by religion. Only two out of the nine Gen2 participants identified their religion as Lutheran and Christian (but not practicing), with the remainder identifying no religious affiliation. This was reflected in the language they used to communicate their understandings about life such as: fate, destiny, karma/cosmic justice, God or a higher power, and luck. They conveyed that life events were at times random, and they dealt with these random events with optimism and resilience, believing that personal growth would result from the experience of adversity. Fiona articulated a belief that fate, being a manifestation of God's plan, played a key role in her life and health, and that a predetermined path had more influence on a person than their upbringing. Her narrative had some elements in common with Frank's (1998) chaos story, where she believed she had little control over illness entering her life. In response to my questioning about how her stated belief in predestination or fate revealed itself in her own life, Fiona used the various narrative excerpts below regarding her blood pressure to support her position. As described by Spector-Mersel (2011, p. 174), she selected an "end point", being the central point of her story (predetermination or fate), and then selected relevant events from her life history that made the central point probable. Through this process, decisions were made about what to include and what to leave out; through these narratives Fiona edited her life history and moulded it into a meaningful story in the interview

encounter. This meaningful story canvassed the past, the present and created a narrative framework for future health decisions:

You know people often talk about nurture and nature, and I think nurture is all well and good and...you have to be nurtured but that's not going to change your predetermined path.

Despite the inevitability of fate, she subscribed to pursuing a healthy life because it might make her feel better generally, even if it may not stop her getting a specific illness. She believed in controlling those things within her control, but accepting that there were some things outside of her control:

I believe somewhat in fate. So if you are going to get cancer you'll get cancer...but there is no point in living a bad lifestyle because that's going to happen, so if that's my destiny to get sick then I don't think anything I do will stave that off...So I think it's a little bit the luck of the draw but there's no point in living a bad lifestyle because of that.

Fiona had high blood pressure but her view towards it was relaxed, and informed by her underlying understanding that illness was fated:

I think I'm probably a bit [more] lax than everyone else in the family about my blood pressure. I don't see it as that much of an issue because I've had it for quite a long time, and how do you know that just because everyone else has that unhealthy blood pressure for other people, how do you know that that's not healthy for me?

I mean I can take tablets to lower it, but if I'm going to die from a stroke I'm going to die from a stroke, whether I'm taking tablets to lower my blood pressure or not. So if the doctor says, "take these tablets", I'll take them, but I still believe that when my time's up, my time's up.

Like a number of the other participants across the generations, Diane did not "paint the devil on the wall" by talking about bad things that could happen, when she told me about her state of health saying: "There's nothing wrong with me yet so (laughing) fingers crossed". Given her family history of disease, Diane was vigilant with screening for her and her family's health, conveying that even if it was her destiny to get an illness, she could still influence her destiny in some cases. Her narratives had elements in common with Frank's (1998) restitution and quest stories. She had a focus on taking action

to conquer disease with the weapon of biomedicine, restoring herself to good health. Her illness journey was also thought of as a quest from which something positive could be learnt:

...because I think if you catch it early enough you can help yourself, or you know, deal with it either way. I don't think just because it's in the family you put your blinkers on and just go "oh well". It's not really a lotto, you can actually do things to change it.

However, if Diane or her family were to get a serious illness:

...I think we'll be strong enough to get through you know whatever is there. And if something's put there, it's there for a reason to test you to see how you come out the other side of it, so yeah. We are pretty relaxed me and my husband, like you know, "just relax". What happens happens, and then we'll sort it out so...it's what we are.

Diane believed in a karma concept that: "things happen for a reason", including some illnesses, in order to challenge people for them to grow. She "sat on the fence" with regards to her stated belief in God, not necessarily believing there was a God, but believing there was some sort of greater power, and that death on earth was not the end of a person's existence. Diane believed she could change her destiny through the choices she made in life. For example, if she experienced serious illness she would not let it drag her down; instead she would face it and try and take the positive learning out of it for her life. She believed that there was always a way to work around challenges, and to learn from misfortune, to make her a stronger person:

...I believe you can change your destiny by what choices you make. Like when things are put in front of you, you know if it's something bad you can let it drag you down or you can turn it into something positive and move on. So I think...you can change your destiny...you can change where you go and end up. And how you live your life as well...

Maire believed that while spiritual forces did exist, they did not directly affect her life: "Fundamentally I don't think that there is kind of any greater or outside sort of influence. Ideally, idealistically I'd like there to be, but I think no, it's a bit more random than that..." Like his sister Maire, Jorma did not believe that any external spiritual or cosmic forces could necessarily impact his life or health, but that there was an element of 'cosmic justice' to life. He had experienced a tragic and unexpected death in the family just a few days before our interview, and these beliefs were illustrated in his approach to making sense of this event. Jorma told me it was no use searching for answers as to why the death happened, because sometimes there was no answer – in life random and unexpected things happen. He preferred to focus on the future, to grieve but then to move forward with life and beyond with

optimism, believing in ‘cosmic justice’ and that generally good things happen to good people who live good lives:

...I try to think that okay what’s done is done, you can’t sort of dwell on things too much...life moves on, everybody’s going to have tragedies in their life and it’s not going to be the first or the last time something like that happens...but...we move on...hopefully how we live our lives is what we are going to move to in the next one. If it would be something better or not I don’t know. But hopefully it is.

8.3. “Hush Hush”

There is some evidence in the Gen1 narratives of subjects that were considered too “hush hush” to speak about openly; Gen1.5 sometimes raised the issues instead. The war experiences of Gen1 impacted on health, schooling, employment and relationships. These experiences also resulted in an element of “hush hush” in their cultural cache, where some subjects were considered too dangerous to discuss. In addition, society in Finland and New Zealand in the 1950s was generally conservative and certain subjects were frowned upon for discussion.

Gen1’s war memories revealed a gendered view. The men remembered their war experiences somewhat positively in terms of impact on longevity and feeling fit and vital in army conditions. The women spoke of interruptions to schooling, relationships, the hardship of doing men’s work, and food shortages. Both men and women remembered how the war created an environment of mistrust of foreigners in Finland and there were some cold war remnants of secrecy that survived, with some issues still considered “hush hush” and not talked about openly. While talking about how safe Kawerau felt when they first arrived, Kaarina commented in regard petty crime in Finland that: “...there wasn’t much other people yet, but somebody most probably might have come over from Russia or those countries”. I remember my Pappa telling me once that in their largely monocultural society they could spot a Russian or foreigner easily, and they were suspicious about whether they were spies. Sakari made a connection between the Finnish name almanac, where all Finnish names acceptable to the Evangelical Lutheran Church are listed, and the government’s role in tracking people particularly during the war:

My name is in the calendar, in there all first names are in calendar 365 days calendar...First of all, Finland always been more, they know where people are. It is important from that kind of location who is who and where they are and what they doing. Legal terms, it was very important

war time, you easily catch any spies, any foreigner, you hear what they talking, they habit, and there was no room for who people who might be coming spying from Russia and that kind of thing.

The war impacted on both occupations and relationships, and when Gen1 emigrated they left behind a cold climate and the memories of a cold war. There had been talk in the shadows of the Finnish community over the years about smuggling during the war where goods were trafficked under the cover of night across the sea between Finland and Sweden, at great risk and adventure. Even now, it is difficult to unearth many things surrounding wartime because the code of secrecy endures. My only view of this history is through a patchwork of whispers, looks, and conversations prematurely ended. A feeling that the secrets of the past could impact the present endures, and the message is that those things are best left to the dead and to the past. Sakari's decision to migrate was in large part influenced by the impact of the war on his occupation:

...war created an environment that my occupation which was commercial fishing, main catch was silver salmon, arctic silver salmon, everyone else started to fish so heavily everywhere else in the Baltic area after war that we run out of fish. Which mean I run out of my occupation. And I was looking then to change occupation and same time, 1954, my wife's brother and his family moved to New Zealand.

The war impacted on many of the Gen1's relationships. Kaarina was orphaned when she was nine years old through the death of both parents. Her older brothers would have raised the younger siblings if they did not have to go to war to fight. The family was split up with the younger children going to relatives and in Kaarina's case, relatives who saw her as another mouth to feed, and a duty to be borne. Kaarina's childhood was marked by hardships which left her feeling unwanted and unloved. Inkeri recalled that her youthful sweetheart was killed in the war, and Helvi's father was killed in the war when she was ten years old, leaving her an orphan as her mother had died when she was only 18 months old. Her childhood was spent in an orphanage, and the subsequent interruption to her schooling left her with some regrets for opportunities missed.

Einari (Gen1.5) remembered something of the trip to New Zealand I had not heard from Gen1 that illustrated the memory of war was still strong in their minds on migration. It also illustrated the "hush

hush” approach in relation to discussing the war; even in the recounting of their experiences many years later, Gen1 did not recall, or perhaps did not chose to share, this event with me:

...when we arrived in Wellington...there was a train waiting for us and it was a combination of the passenger carriages and cattle carriages and the Finnish people, there were 19 families there with all the kids at the platform there, and the Finnish people refused to go on the train they said “we will not go on that train alright, we will not go on that train because they’ve got cattle and they’re going to take us to some bloody concentration camp and kill us”...And the actual train was delayed there for at least an hour when the people were waiting for us to go on board and we actually refused to go on board because we wanted some sort of an assurance...then it was able to be solved [with the interpreter] that “no no, we aren’t going to take you to a concentration camp alright” then we actually boarded the train...

The issue of pollution from the Tasman mill also emerged as a “hush hush” issue. Many of the Gen1 participants lived and worked in mill towns, both in Finland and then in Kawerau. While they acknowledged some questions surrounding the issue of Tasman pollution, most were reluctant to make a firm connection between their employer (in many ways their benefactor), pollution and health. This could have been a conservative approach due to a lack of firm evidence, or, in some cases, perhaps out of loyalty to ‘Uncle Tasman’ and not wanting to acknowledge that the company that looked after them and their families so well may also have been responsible for poisoning their environment. In her study of mill wives in Kawerau James (1985, p. 29) found that: “The company as the source of livelihood permeates almost every subject. In talking about pollution from the mill, many residents are privately critical, but publicly silent” and that: “...residents were resigned to, rather than accepting of, pollution problems in the industry. They are aware of the connection of pollution with their livelihood, and the ambivalence surfaces again: ‘It’s a rich smell, put it that way’”.

Sakari reflected that in Finland the old chemical methods used in the mills resulted in many men dying from various forms of chemical poisoning, and this made him wary of working in the chlorine or pulp mill at Tasman. He also remembered that the general feeling in the early years was that the pollution from Tasman was bad for your health. However, it was hard to know for sure because he said people in those days did not openly talk about these types of concerns, or even about why people died, so the issue was shrouded in secrecy:

Reason for dying in almost every society is more or less hush hush. People don't want to tell "he died for cancer" or "he died for venereal disease, vd" or "he died for heart" or something. People don't want to tell for really, they just died. I don't know why, he just died. Because family want to keep it confidential and so on. So I don't have a black and white information but anyhow that is how people talk was going around. So, it was definitely very highly high degree of environmental risk and people probably even animals has to eat that grass, with all poison in. But at that time also they were using that 2-5T or whatever the chemicals and sprays – but river was black, river was black.

Inkeri did not think the mill in Finland her Dad worked at caused the workers any illnesses, but also reflected that: "...they did not complain anyway. Finnish people normally, menfolk particularly, they don't complain - they suffer in quietness". She did remember there being a lot of talk over the years about the pollution caused by Tasman, but she did not think that affected her or her husband because they had been used to living in a mill town in Finland, and also because her husband was not working specifically with chemicals. She also thought that because of where Kawerau was built, the prevailing wind took the smell and any pollution away from the town, and so people living in Kawerau were not affected.

Helvi told me she did not think that the pollution from Tasman caused illnesses, however, she did tell me a story about a group of cancer deaths that claimed the lives of some young people that concerned her, but was never really talked about. This illustrates the ability of narrative to reveal and construct understandings that may not emerge otherwise:

I tell you what happened in this area, and still managed to ignore it, there was Bob Smith's³⁷ daughter, there was Jim Jones, there was a boy Robinson...and there was Jane Marshall, they all died of this same thing...some kind of a cancer. And my friend said to me once..."have you ever thought it having to do with the gases?"

Helvi told me she hated to think it was from Tasman but that:

...it's kind of eating me a bit, all this beautiful...all of them lovely lovely kids. And they were really close together, inside a year or two. So, I don't know what the others think, because to tell you the truth, there are not very many Finnish people in this town, and never had really really been, who would discuss things like that. Not many.

37 Names changed to protect persons identified

Gen1.5 and 2 made very little mention of Tasman at all, and only one talked about avoiding certain areas in the mill due to the perceived danger of chemical exposure. A further example of “hush hush” was when Gen1 were not particularly forthcoming about the reasons why the Finnish Club eventually dissolved, as discussed in Chapter Five. Even though many of the members had long since died, Gen1 participants were reluctant to discuss details and skirted around the edges of the interpersonal conflicts and conflicting views that divided the group. Some of the Gen1 participants told me later “off the record” that one of the disagreements that festered in the Finnish Club stemmed from differing views about Maori. They wanted me to know this detail, but did not want their name associated with the comments. One step removed from the events were Gen1.5 participants, who were forthcoming about their views on the demise of the Finnish Club. Katie remembered feeling part of the Finnish community, but reflected that this was both a good and a bad thing. The good side was the early years of close camaraderie and activities, and the bad side was hearing about the eventual dissolution of the Finnish Club, and the interpersonal conflicts that went along with that. As Gen1.5, Katie was on the periphery of any conflict, and told me that she did not think her generation had those same types of issues. Like Hilja, she suspected the Gen1 issues may have stemmed from the Finnish class system, where some people felt they were better than others, and others felt that in New Zealand everyone was as good as each other.

In discussions regarding food, alcohol emerged as a shadowy theme. All Gen1 touched on the subject of alcohol consumption, and commented that the Finns are big drinkers. However, the comments were made as asides and it was difficult to elicit detailed discussion on the subject. I had the impression that alcohol was acknowledged as a health issue for Finns both in New Zealand and in Finland, but it was, again, one of those “hush hush” subjects. Drinking was acknowledged as being part of Finnish culture, and underlying most comments was the notion that while alcohol itself was not bad per se, it could become a problem when consumption was not controlled as illustrated by the Finnish saying: "Viina on viisasten juoma", meaning that alcohol is the drink of wise men and should not be drunk by people who were unable to control themselves. Helvi said: “...you know that Finns drink an awful lot and that can’t do too much good for their brains, not just one or two or three but the whole lot”. She put the heavy drinking culture down to Finnish prohibition and governmental control over alcohol having the reverse effect on the population. Sakari remembered the difference in alcohol availability between Finland and New Zealand, and that for many of the migrants this presented difficulties. His narrative revealed a moral aspect, in that some people were not able to control themselves personally around greater alcohol availability:

Finland always, and at that time particularly was still very, controlled alcohol availability. What you can buy from shop, can you brew your own? It was illegal to do so. You cannot go to shop and ask I like to buy ten litres of vodka – it did not work that way. But here it was free...for many one it was overwhelming temptation.

Over the years I have heard many “hushed” stories of alcoholics in the Finnish community, or stories of people who have died or become ill from alcohol related illness. Running through these stories have been opinions about people not being able to control the alcohol, or about the drinking ruining their insides. Men, in particular, should be able to drink their share, but should also be capable of controlling their alcohol consumption so it does not ruin their lives or health. This view reflected Gen1’s outlook on life that people need to be responsible for themselves and their own personal behaviours. A few of the Gen1.5 and 2 male participants mentioned alcohol in the context of moderation, reflecting how they had seen excessive consumption by their parents and they knew that moderation was important for the sake of their health. However, this was always communicated in a half-joking way, which I took to mean that while they acknowledged the negative health impact of heavy drinking, there was also a kind of respect associated with being able to drink heavily. This is still very much part of modern Finnish culture, and I observed this first hand in midsummer when I visited Finland in 2007 where there was evidence of heavy alcohol consumption in public places.

Despite the dangers, alcohol could be curative, according to some of the stories told to me by Gen1. My Pappa would treat a bout of influenza with strong alcohol and lying under plenty of blankets as a way to use heat to kill the bugs in his system, bringing to mind the old Finnish saying that: *Jos ei viina, terva ja sauna auta, niin tauti on kuolemaksi*” meaning that if tar, liquor and sauna do not help, then the disease is fatal. A stiff drink of spirits would often be used to calm the nerves, or counter the effects of a shock.

8.4. The Cold and Dark Pohjola

As discussed in the previous chapter, the meaning of sauna has changed across the generations. This section explores the Finnish religious belief in the health-giving aspect of health and steam that underlies the Finnish sauna tradition, as well as other aspects of Finnish religion that operate at a level below consciousness and influence how the participants’ think and act in the field of health.

Finland has a long history of religion which predates the Lutheran Reformation (1520s to 1593). Alhonen (2006, p. 1) labelled Finnish religion 'paganism' (arguably a pejorative description) and proposed that: "...paganism and Finnish culture do have a lot in common" and that: "Paganism was a collection of customs and beliefs concerning both supernatural and everyday things". The Finnish religion is apparent in music, the arts and modern day cultural practices in Finland. Finland's famous composer, Jean Sibelius, frequently used themes from Finnish religion in his works. Traditional folklore, which is based on Finnish religion, is revealed through sauna customs and cultural practices which continue to the present day. The national Finnish epic, Kalevala, is a collection of mythical folk poems. Alhonen (2006, p. 1) proposed that even: "...after a long period of Christianity, people still held many pagan beliefs and practices even centuries after conversion, especially in the Karelian areas. Some of these beliefs and practices survived well into the 21st century..." and that: "Even today, many traces of the old Finnish paganism can be seen and heard in the Finnish language, place names, customs, methods of traditional healing and in national holidays". For example, Juhannus or midsummer celebration around the summer solstice continues traditions of bonfires and raising may poles, even though the Lutheran Church pronounced it to be a celebration of John the Baptist's birthday (Alhonen, 2006).

According to Finnish religion, one of the primeval gods present at creation of the world was Väinämöinen. Alhonen (2006, p. 1) described this god as: "...a master healer and defeats all diseases, which come from the cold and dark Pohjola". Pohjola is a location in Finnish mythology which translates as Northland. It can also mean an abstract place that represents an evil, cold, dark land. Illness, frost and misfortune hail from Pohjola. Finnish religion held that people had multiple souls and one these souls was henki, life-force or breath. Henki manifested itself in the warm breath of the living body and the original word for henki was löyly. In ancient times, if you lost your löyly, you lost your life. In modern times, löyly refers to the hot air in the sauna, and getting the right level of löyly in the sauna is considered a skill and an art. Getting the optimum sauna löyly used to be important for wellness, as sick people were often treated in the sauna.

Suomi (Finland) is about as far north in the world as it is possible to go and the climate is severe with temperatures falling to as low as minus 30 degrees Celsius in the north. Winter is the longest season in Finland with the polar night lasting for more than 50 days north of the Arctic Circle (Encyclopædia Britannica Online). Genl's theory was that being properly warmed up, either through sauna or other means, was an important factor in good health and the warmer weather played a role in the decision of

Gen1 to migrate, and subsequently to stay in New Zealand. Both Gen1 and 1.5 cited the cold Finnish weather as a primary reason why they would not go back to Finland to live. They proposed that warmer weather was more beneficial for health and happiness than cold. Sakari told me that the warm New Zealand climate had added many years to his life, both through the availability of fresh food, and by creating a less stressful environment for living:

...weather wise, it was not so demanding here, because colder winter situation in Finland, where body has to recuperate more against staying okay in that kind of environment...Probably give five ten years difference in life. Particularly in the health...

Like the other participants, Kaarina proposed the cold Finnish environment resulted in cholesterol problems, which became embedded genetically into the population, and that the cold climate also made Finns more susceptible to germs in the environment. For Helvi, the cold and dark winter months in Finland contributed to feelings of sadness and depression. Like other Gen1 migrants, Niilo felt that even though New Zealand was a “summer country” the houses were colder than in Finland and that this contributed to poor health in some people. As discussed in Chapter Five, when they first arrived in Kawerau, Gen1 and 1.5 felt cold in their weatherboard homes which were not well insulated and were only heated by an open fire. In Finland, while it was much colder outside, the houses were well insulated with double glazed windows and doors, and central heating. This is the reason why Niilo and the other Kawerau Finns ensured their houses were properly insulated and heated; they arranged for additional wall, ceiling and floor insulation, and additional heating for their houses in the first few years of being in Kawerau.

My Mummu, like the others of her generation, has always been concerned with protecting the body from the cold, and believed the cold could enter the body through orifices and openings in the skin. Keeping warm and protected by wearing warm clothes has been taught to each generation by Mummu, as well as the importance of covering up any wounds from the cold. I remember Mummu telling me that if the cold gets in to the body through a wound in the skin, then you would be opening yourself up to risk of illness or infection. I had a root filling once where the tooth was packed for filling at a second appointment, and she advised me strongly to wrap a scarf around my mouth to make sure the cold did not enter into the wound so I could avoid infection. The skin serves two functions according to Gen1. Firstly, it protects the internal body from illness which can come from the cold or germs, and secondly it allows for toxic things to exit the body through perspiration which is why it is important to be properly “heated up”, as described by Inkeri:

Yes, well wherever the Finns go, they go up to Darwin with the hot climate, they still have a sauna... So when you come out of the sauna and you have had perspired, your body gets rid of all the toxic things...

A soul in Finnish religion was “itse-soul” which refers to the essence of oneself, or one’s self-image. If a person lost their itse, they could become sickly, depressed, and unlucky (Alhonen, 2006). Alhonen (2006, p. 1) commented that: “Sometimes the ghosts of already deceased loved ones might lure a person's itse to come with them to Tuonela or Manala [the underworld] while the person was still alive”. Finnish religious beliefs about death were that it took 30-40 days for a person’s itse-soul to find their way to the underworld. During this search, the itse-soul might visit loved ones as a ghost or an animal. Everybody had a guardian spirit called Luonto which influenced their character and nature. If a person’s Luonto travelled ahead of them to give people the sense that they were coming, this was considered positive or neutral. However, if the sensation of a person’s Luonto lurking around when the person had already died was considered extremely bad thing (Alhonen, 2006, p. 1). Spirits were thought to be powerful influences whose purpose was to guard, help or protect somebody or something. However, they could also cause misfortune, including illness.

I have observed over many years that there is some unarticulated knowledge about the foretelling function of dreams, as well as actions that may invite evil into life such as talking about bad things that might happen, thereby encouraging or inviting them to happen, as previously mentioned. Siinä paha missä mainitaan (evil is where it is mentioned), and älä maalaa satanaa seinään (do not paint the devil on the wall), are old Finnish sayings meaning that you should not talk about bad things that might happen to loved ones lest they might come true. Finnish religion may have influenced the current day view of Gen1 that prayers should be asking God to “please keep loved ones safe”, and not “please do not let them have an accident on the dangerous roads”. Thinking negative thoughts may breed negative consequences for one’s life, and thinking positive thoughts bring about positive consequences. This may have contributed to the participants’ disposition for optimism, which in turn influenced their conceptions of health. I have heard many stories of the Finnish women, in particular, having meaningful dreams about loved ones, and then getting the news that the person had died. For this migrant community, half a world away from loved ones, the time difference between countries was reported as being accounted for in the dreamtime, leading to an unspoken conclusion that the person’s spirit had entered the dream to wish a final goodbye.

Some Gen1.5 participants were reticent when questioned about spiritual or cosmological aspects to life. When I asked one participant if he thought something like fate or God's will could affect his health he said: "No, I don't think so. I don't believe in that sort of crap but ah..yeah. Next [question]". Sandra, like some of the 1.5 participants, reacted nervously and uncomfortably when asked about a spiritual or cosmic aspect to health:

Kerrie: What do you think about when people talk about karma or fate or God's will, because some people think that, you know, external spiritual forces can bring misfortune in your life or illness in your life. Do you think anything that is out there in the universe could affect you and your health?

Sandra: (thinking) Yeah...(looking at tape, looking at me, looking at tape, looking at me, laughing nervously)

Kerrie: Don't be nervous, I promise you it will be fine (laughing).

Sandra: I just got funny beliefs like my mother (laughing).

Kerrie: Tell me about it.

She told me about an experience akin to those described by Gen1, harking back to Finnish religious beliefs. While she believed it was true, it scared her and she had no desire to pursue anything like that saying: "There are things its best not to know". She preferred to live her life grounded in the physical world, not a spiritual one, even though she felt that option was available to her because of her susceptibility to spiritual things. Similar sentiments had been expressed to me by others of her generation over the years.

8.5. The "Finnish Curse"

As mentioned in the previous chapter, the concept of the Kawerau doctor-named "Finnish curse" of high blood pressure, high cholesterol and heart disease was a factor in the lay model of health across generations post migration. This section further explores the "Finnish curse" through the participants' understanding of genetic heritage and the implications for health and habitus.

It was the understanding of all three generations that certain illnesses, such as heart disease, are genetic, and these illnesses develop in certain populations due to their location on the earth and the behaviour of previous generations. They proposed the resultant hereditary genetics could influence their health.

This understanding of genes reflects the individual lay theory of illness causation, with the view that some origins of ill health originate within the body, but outside of the person's conscious control, including personal and physical vulnerabilities such as genetic traits. This includes the idea that some people, and even families, are born naturally less resistant to illness than others, and that environmental circumstances, such as living in a cold climate, can create physical vulnerability. According to this theory, both personal and physical vulnerabilities can be mitigated through personal endeavour such as diet, exercise, and resisting emotional tendencies (Helman, 2007).

The colloquially termed "Finnish curse" of high blood pressure, high cholesterol and heart disease, cast a shadow of concern over all three generations interviewed, and influenced their health practices. Despite their genetic heritage, however, they said they could still make choices around issues such as diet and exercise that could mitigate some of the negative impact of genetics. They conveyed that it was important for them to avail themselves of knowledge to inform what actions they should take if they had a genetic predisposition to illness. Even if some genetic illnesses were supposedly unavoidable, they suggested they should still try their best to minimise the impact. Again evidencing a moral component to their conceptions of health, participants described their genes using words like "strong" and "good", or, "weak", "wrong" or "bad". One noticeable shift in thinking between the generations was the emphasis on genes being considered "strong" or "weak". Gen1 mainly conceived of their genes as introducing risk factors into their lives, and while both Gen1.5 and 2 concurred with this view, they also understood their genes could offer a protective factor. This could have reflected Gen1's view that the cold of Finland and the national diet resulted in genetic risk factors for their forefathers, whereas the descendant generations may have supposed living in a warmer climate and consuming a healthy diet resulted in mitigating factors. The perceptions of vulnerability to genetic risk could also have been influenced by the salience given to personal experiences of illness in the family, and also shaped by family narrative, where: "...perceptions of vulnerability are situated within a complex framework of kin relationships into which new information is integrated..." (Lindenmeyer, Griffiths, Green, Thompson, & Tsouroufli, 2008, p. 276)"

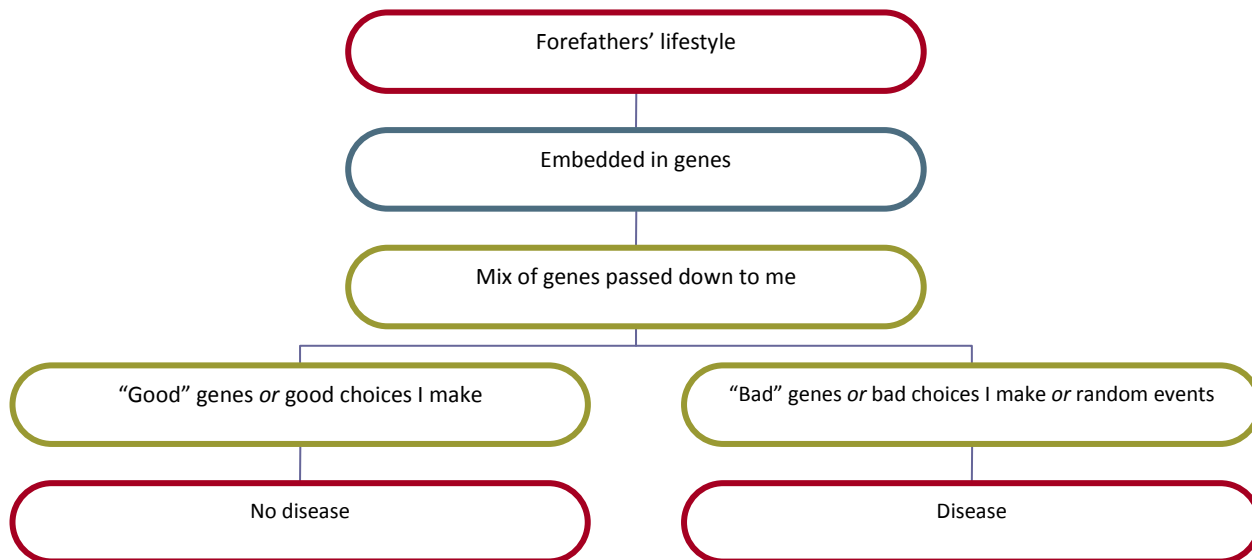


Figure 21 Generational Concept of Genetic Heritage and Health

In my observation, Gen1 were very knowledgeable about their blood pressure and cholesterol, having actively monitored this for many years either through regular visits to their general practitioner, or through the screening provided by Tasman. As a result of this monitoring, or as a preventative measure, they took specific actions in an attempt to manage any unfavourable results, such as changes in dietary and exercise practices. They took these actions even though they accepted some genetic health problems were inevitable, reflecting their structuring disposition to be self-determined, self-responsible and optimistic as previously described.

Helvi conveyed the only thing she could do to counter inherited illnesses was to eat the right food and live the right way, including not having any bad habits such as smoking. However, this relationship was not straightforward in her mind, as, in her view, she could do all the right things and still get sick. Conversely, she could have bad habits and remain well. She remembered being very slim, fit, and eating a healthy low-fat diet when she developed diabetes and high cholesterol. When she went to her doctor in Kawerau he took her hand and said: "...you poor thing, you've got a Finnish curse". Helvi explained she had inherited these conditions and that she could not avoid them completely, even though she was making good choices in her life. Like others of her generation, Helvi took a moral stance to genetic predispositions, conveying that genetic heritage resulted from the behaviour of generations before, and that personal behaviours/habits could impact on genetic structure:

...people in Finland had to work so hard, especially in the forest, from early in the morning until late at night. And they were felling trees and they came back and they probably did not eat much during the day. And they got into the pork fat, and all this because they needed and they believed

that fat was the only one that was nourishing them, and that's when it got to the genes. The generations of that fat diet because of the hard work and the cold – this then became the genetic condition we Finns have now.

Kaarina explained that her: "...heart problem is most probably inherited because my father have died of a heart attack...I had four brothers, three of them have died of a heart attack. I had one sister, she has died of a heart attack. So, I think my heart problem is more inherited". When I asked why she thought she had outlived all her siblings she said:

I think because I have realised early that the lifestyle that you are living and the way you are eating can make it much worse for the kind of problems with the heart. Too much fatty food, and too much food actually altogether. And exercise, because exercise is one good thing that...as far as I'm concerned, it keeps me going.

Again, like others in her generation, there is a moral aspect to the narrative, with Kaarina indicating that personal choices regarding diet and exercise could contribute to heart disease.

Inkeri said it was important to try and live a healthy life, despite her genetic heritage. Her narrative revealed that regardless of continuing genetic advances, the moral aspect of personal responsibility with regards to illness persisted, with the understanding that one should still try to better one's life whatever the circumstances:

...as you grow older, they may not appear in your younger years, but as you grow older, you know what is inherited. And there are even some things that doctors agree with you, which they can't do anything about because it is inherited...you must still try to better your life whatever way you can...All the things even scientists have medically improved so many things and they are all available these days for everybody if only you like to know and read and learn.

Like Gen1, Gen1.5 conveyed that genetics played a role in their health, both in terms of making them more susceptible to certain illness and that "strong" genes could protect them from the consequences of bad health choices in life. Many thought they had inherited the "Finnish curse" of high blood pressure and high cholesterol and so they took steps to monitor and manage this, even though they did not think their actions could totally mitigate the negative impact of genetic heritage. Like Gen1, they all put the

“Finnish curse” down to the bad diet and harsh conditions experienced by previous Finnish generations, manifesting itself in the genes of the present generation.

Hilja’s view was that she was healthy because she was not on any medication, and was managing the “Finnish curse” through good diet and exercise. She put her good health down to the choices she made, as well as strong genes inherited from her father. Like many others of her generation, Hilja considered a strong genetic heritage could offer protective factors. Optimistically, she conveyed she kept the impact of her mother’s weaker gene pool at bay through diet and exercise. Hilja said that: “I’m sure it’s lifestyle choices and food choices plus genetics that we probably don’t know enough about yet”, and went on to say that there are some genetic things one can’t control, but that there are some that can be counteracted with good diet and exercise before having to consider medication:

I’m really anti chemical intervention, so in that respect, because I know that I can have high blood pressure, and I could maybe have problems with my heart on account of the familial weakness on my mother’s side. I have taken measures which is that I exercise, I eat a lot of omega, I eat a lot of fish so omega fatty acids, I eat very little meat product, I don’t eat animal fats hardly at all, I eat a lot of leafy greens and bright vegetables. I exercise for an hour, a minimum of an hour, each day five days a week...and those things might be helping that, but, I don’t still think that I’m never going to get any of these things because I’m doing this.

Rauno admitted to some unhealthy habits, but proposed that his good genetic heritage offered him some protection, along with his lifelong exercise regime, having pursued his sporting interests from childhood. This, again, evidences the strongly gendered link between sports and health for many of the Gen1 and 1.5 men in the study. He also understood his genetic heritage made him and his children more susceptible to certain illnesses, but that there was nothing to be done about that other than to be moderate with habits such as moderate alcohol consumption, and exercise.

Aino watched many of her family members suffer from heart conditions and die prematurely, and decided in her 40s that the same thing was not going to happen to her. She radically changed her diet and exercise regime, had kept very good health, and was living longer than her parents and sibling. While Aino said she had the “Finnish curse”, she conveyed that her healthy diet and exercise, as well as taking medications, had contributed to her avoiding her genetic fate:

...I'm now eating blood pressure tablets and cholesterol pills and all of that, which the Doctor even agrees it's genetic, and you know he says...well you could eat all the grass under the sun and your cholesterol, it's the...Finnish curse.

Einari thought his major health problem may have been as a result of a stressful lifestyle: "But then I went to the...specialists, and they said this is something from the genes and when they found out I was from Finland...they said this is a typical Finnish problem...they said "...hey you're just one of the unlucky ones, you've just got those wrong genes". However, despite his seeming acceptance of the doctor's advice that the issue was genetic, Einari did take concrete actions to reduce stress in his life indicating that despite the doctors' explanation as to cause, he still believed that stress contributed to his major health problem. This reflected Einari's self-determined character, and how deeply held conceptions of health influence practice.

Like the previous generations, Gen2 understood that the circumstances and habits of their forefathers became embedded in the genes of their family line, and that these genes were eventually passed down to them. Gen2 did not have two Finnish parents and so they thought of their genes as a mix, and therefore felt a measure of protection against the "Finnish curse". There was an association between conceptions of identity/belonging and the impact of genetic heritage – the stronger the identification with being Finnish correlated with feeling more susceptible to the "Finnish curse". Gen2 thought that if they practised healthy habits, this may or may not result in illness. Similarly, if they practised non-healthy habits this may or may not result in illness. This was because, in their view, that while healthy habits may mitigate genetic risk, it could not mitigate all the random events in life which may result in a manifestation of illness. Conversely, and like Gen1.5, they understood that good genetics may offer them protection against unhealthy habits. On balance, however, this generation preferred to act on the side of caution and pursue healthy habits, while acknowledging that this would not necessarily offer them complete protection against illness. For example, Linda thought genetics played a part in health, but that the links were not always clear and that sometimes poor choices contributed more to illness than genetics; therefore diet, exercise and living in a healthy and emotionally stable environment could counteract some genetic illnesses, and may even prevent some genetic mental illnesses from being triggered. However, she viewed the issue as complex, and even if people did all the right things and lived in a good environment, illness could result. Having experienced the impact of mental illness in her family, Linda and her family had been working through a process of trying to understand why this happened – Was it genetic? or environment? or a trigger of some sort? They concluded they will likely never find the answer. They had a pragmatic approach to the issue, just got on with life and dealt with

the ups and downs as they came, although at times it was hard and Linda sometimes felt some sadness for what might have been if this “thing” had not come into their lives.

Carl, like his mother Aino, was well aware of his Finnish family genetic history of the “Finnish curse” with many family members dying young from heart related conditions, and told me: “I’ve been warned, my brother’s been warned about how we need to make sure that we physically look after ourselves”. Carl took this warning seriously and was vigilant with monitoring his blood pressure and cholesterol, as well as having a good diet, exercising and keeping his weight to a healthy level. Having worked at Tasman for many years, he had regular health checks with the Tasman doctor and now, having left Tasman, he wanted to carry on with that screening and would not hesitate to visit his general practitioner if he felt unwell. Despite taking all these actions, Carl acknowledged that illness may still result despite taking all precautions.

Mirja thought there were a number of factors that contributed to illness including genetics and environment. She felt that while genetics was a factor, people could take actions to minimise the impact, and if they were aware of their genetic heritage then they should take actions sooner rather than later. Her narrative reflects a moral aspect to illness, where even genetic conditions can be avoided if you take personal responsibility for your actions. Conversely, blame could be ascribed if illness develops:

I don’t know if you can avoid it, but you can avoid it becoming troublesome, I think. If you’ve got a problem that is linked to genetic makeup that you can – say it was high blood pressure...I think then you could be doing things like, not smoking, relaxing, exercising, to avoid it being an issue. Whereas if you are predisposed to having high blood pressure and you are to smoke and have a stressful life and not exercise, then of course you’re going to be more likely to suffer.....like they say Scandinavians have high cholesterol so you’re always aware of that so then you can be starting to make changes with your healthy eating to make sure then if you think you’re more likely to have high cholesterol than someone who’s not Scandinavian then you make those changes now before waiting...

8.6. Summary

The participants' health and illness narratives reflected their wider life circumstances and experiences, and how they made sense of these provided a glimpse of the reproducible and generative nature of habitus in the field of health. A self-responsible, self-determined and optimistic structuring disposition to think, feel and act was reproduced across generations. These dispositions shaped reasons for good and ill health and influenced whether or not health care was sought, the kind of care that was sought, and the participants' approach to compliance with medical advice. The principle of fate was also reproduced in some form across generations and influenced the participants' conceptions of health and health behaviour.

The notion that habitus is inculcated by the biographical and historical experience of the individual (Bourdieu & Wacquant, 1992; Brown et al., 2008) was evidenced by the "hush hush" narratives of Gen1. Their war experiences in Finland resulted in a propensity to be guarded around certain subjects and this was not reproduced in future generations who had not experienced war or conservative 1950s society. In this way, their patterns of thinking and acting were influenced by: "...the public meta-narratives regarding what constitutes appropriate, gendered behaviour(s) or expressions of belief" (Robertson, 2006, p. 178). Aspects of Finnish religion also appeared to function at a level below consciousness and influenced how Gen1 thought and acted in the field of health. Like the experience of war, Gen1's unique connection to Finnish religion was not significantly reproduced in future generations who lived most of their lives in New Zealand; it only appeared briefly as a slightly uncomfortable "hush hush" subject for some participants in Gen1.5 and 2.

This chapter found that how the participants made sense of their perceived genetic heritage influenced their health practices. This supports the notion that people are embodied differently from birth, and that the body is not simply a carrier of habitus, but is worked on like other forms of capital (Shilling, 1993; Wacquant, 1995). Genes, as carried and revealed through bodily function, could be thought of as a form of bodily or embodied capital that is accessed in the field of health (Meinert, 2004). Finally, this chapter evidenced how a variety of data sources such as review of historical, policy and archival materials, narratives that emerged in interview encounters, social situations and stories told to me as a member of the Finnish Community over a lifetime, as well as my observation of the Community (both in my role as an 'insider' and 'outsider') produced a highly textured 'portrait of a people'.

Chapter 9. What Stories Revealed About Health

9.1. Mummu's Story

As I was writing this final chapter my 83 year old Mummu attended an appointment to investigate the source of on-going stomach pain. While waiting for the procedure she was admitted to the intensive care unit at Whakatane Hospital and later transferred to Waikato Hospital Cardiac Care with chest pain and life threatening high blood pressure. After years of monitoring her blood pressure and cholesterol and treating with diet, exercise and medications, it appeared the “Finnish curse” was catching up with her. This section reflects on her experience of illness and illustrates how narratives in a migrant context can reveal patterns of thinking and acting in the field of community health.

At the beginning of this study I wondered if we were doing enough to accommodate the health needs of white non-British migrants, a somewhat silent and invisible minority in health policy and services. Mummu had a good command of the English language but in pain and weak, confronted by health professionals for whom English was a second language, she relied on family for translation. She sat attentively and politely while various health professionals fixed her with their various ‘medical gazes’, asking about her symptoms and describing her disease. Once they had finished speaking she would look to family and say “Mitä he sanovat? (What are they saying?). Mummu had at least one family member with her at all times through her weeks in hospital and I realised how important it was not only for translation, but also to make sense of the complex medical language, activity and decisions required as Mummu fought to retain agency in the medicalised process. Later, Mummu reflected that in the more than 50 years she had been in New Zealand, Finnish medical terminology had evolved. This presented further difficulties as she attempted to translate everything from English to Finnish to aid in her understanding and decision making. Even when she was very ill she was determined to make decisions for herself – to the outside world she appeared as a rather demure lady but her friends and family know she has a feisty side, and can be very determined.

Advocacy and support from family was also important for briefing the various teams from various specialities, shift changes and across hospitals. There were occasions when we picked up on things that were missed, not handed over, or not followed up on. Even Mummu in her weakened state picked up on potential medication errors, politely challenging the dosage and asking why certain medications were missing from her regime. The overall care she received was efficient, effective, safe and

compassionate and we were grateful for our health system which was there for Mummu when she needed it.

Once the various decisions regarding treatment options were worked through and agreed with the doctors, family discussions around the hospital bed turned to descriptions of the illness as we collectively tried to make sense of what had happened, why it had happened, what we were going to do about it, and what it meant for the future. The discussions drew on illness events from the past as well as information we ‘googled’ while in hospital. The doctors said Mummu had had a heart attack because her blood pressure was not being managed by her medication regime, and her arteries had some blockages. We felt the heart attack was brought on by the stress of her stomach problem as well as apprehension on the day of her gastroscopy, which caused her blood pressure to skyrocket. Mummu and the family believed that she has lived so long (much longer than other family members who died from heart disease) because of the choices she had made with diet, exercise, monitoring, a positive outlook and medications but that the “Finnish curse” would likely catch up to her in the end. It also emerged that Mummu had been having quite severe chest pain for a while but she put it down to having overdone it, or eaten something that did not agree with her. She did not want to worry us by telling us about it and felt it was not bad enough to go to the doctor. She knew if she told the family we would have insisted she see a doctor, and she did not want a fuss.

Mummu told us repeatedly during her hospital stay that she could do all the right things and the doctors could do all the right things, but that when her time was up it was up, and only God knew when that was. She also told us that people should use their God-given brains to seek appropriate medical treatment, but that ultimately her fate lay outside of medical science. This resulted in her decision to be transferred to Waikato for further treatment, even though her doctor at Whakatane initially recommended a ‘do not resuscitate’ order and that she be medically stabilised if possible and sent home. He did not think that Waikato policy would accept Mummu for admission. At that point the family considered a number of options including private care, or putting her in a car and driving her to Waikato Emergency Department, thereby forcing an admission in order to fulfil Mummu’s wishes. Once we got to Waikato, her doctor there told her that they would do all they could to save her and this illuminates that how people understand health directly impacts on treatment. Through the process she encouraged us all to pray, because that would help us to get through whatever was ahead of us. She also prayed for the doctors and nurses who were treating her that God would give them the knowledge

to do the right thing for her. Because of this, she felt at peace with what was happening. While we were all just holding it together, she remained calm and accepting throughout.

Mummu could not keep anything down her first few days in hospital, and all she wanted was Pappa's smoked salmon on rye crackers. He brought some in for her and much to our surprise, after not eating for many days, she was able to eat it and keep it down, saying she felt much better after having eaten it. Later when home she told me she should be able to regain the weight she had lost in hospital because she was able to eat Pappa's salmon and pulla. Once home, she was concerned about the side effects of her new medication regime. She had been having unsettling dreams, and was relieved to find that it was a noted side effect of one of her medications, not some portent to be deciphered. She had always led a very active life and was coming to terms with her recovery phase where she could not do certain tasks and needed to rest. Family discussions about the utility of certain medications given, the side effects of weakness and feeling tired, were underway.

Mummu's story illustrated a number of the findings of this study. Health is a complex 'mirage' and is represented by peoples' lay models and these emic understandings are revealed through a process of narrative 'sense-making' which can be generated and reproduced in family settings through the experience of illness. Mummu's experience reflected the lay models described in Chapters Seven and Eight, but also recreated and shaped them through the illness encounter. This unique lay model differed considerably to the 'medical gaze' of the health professionals who treated her. Narrative both revealed and transformed; how Mummu and the family constructed the story of life threatening illness will influence how we approach this in the future. Mummu and the family drew on their capitals, providing resources and power in the process as we navigated the public hospital system as advocates for Mummu's wishes. Mummu appeared to the health professionals she encountered as a 'British-like' patient, but actually needed language support and drew on her Finnish cultural cache, including the notion of Finnish food as healing, to make sense of the experience and inform her decision-making in hospital and once home.

9.2. Conclusions of the Study

In light of the importance of community health in a multicultural context, this study set out to answer the question: What are the health understandings and practices of a Finnish migrant group and their descendants in New Zealand, what has influenced these understandings and practices, and how have

they developed and changed over three generations? The specific objectives of the study were to: discover the migration and health experiences of three generations of a group with a shared Finnish migrant history in the Bay of Plenty; investigate the influence of life experiences (such as migration and policy) on patterns of thinking and acting with regards to health; and to investigate evidence of generational change. These objectives were delivered through a thesis that took a narrative form, telling a multigenerational story through policy, the experience of migration and food, and revealing models of health keeping which were deeply embedded in embodied social experiences. In sum, this study sought to find out what stories across generations of a community founded by migrants can reveal about health and health keeping, and how participants think, feel and act in the field of health in the light of their shared migrant and policy history. Through narrative, the study revealed a unique and influential lay model of health that was shaped by the capitals provided through the experiences of policy and migration, and which was transferred across generations through the habitus. Anthropological approaches were used within the theoretical frame of habitus for the enquiry, and found that everyday life experiences, unique lay models of health, and a sense of identity and belonging, had an influence on what the participants understood about health, and on their health keeping practices across the generations.

The research added to the body of community health literature identified in Chapter Two. Narrative ‘sense-making’ revealed how health is a ‘complex mirage’ with Chapters Seven and Eight finding that understandings of health defy simple homogenous categorisation, and Chapters Four, Five and Six finding that health encompasses wider structural components that can provide (or reduce) capitals. The lay models of health described in Chapters Seven and Eight gave shape to the ‘complex mirage’ and showed how health understandings can influence health keeping practices, are embedded in embodied social experiences, are culturally constructed, and can be transferred across generations through habitus.

This research took a Bourdieusian theoretical approach to health in the context of a group with a shared migrant history. Bourdieu’s (1990b, 1999) interrelated notions of habitus, field and capital were employed to examine both structural circumstances and meaning. From the ethnographic data one can see the generative and improvisory characteristics of habitus across generations; the way things are thought about and done are both passed down and open to change as the result of experiences in various fields, such as the field of migration. For example, the Finns put traditional class differences aside when they first came to Kawerau in forming the structures of the supportive Finnish Community

and this contributed significant social, cultural and symbolic capital to the migrants which continued to benefit future generations in some way. The Bourdieusian framework was useful because it addressed both continuity and change and assisted in keeping both in focus simultaneously.

Through habitus and concepts of culture, the structures of social being, foundations of knowledge and the hidden possibilities of history (Wacquant, 2006) were investigated and revealed something about the health of a multigenerational group with a shared migrant history in New Zealand. The participants' social practice of habitus developed from their structural position in the field and was enabled by various capitals including economic, social, cultural, food and body capital. This provided them with significant resource and power advantages in the fields of health and migration and various capitals were found to be transferable between generations.

Government migration policy in both Finland and New Zealand provided economic capital through the legal right of movement between countries to pursue employment. However, only Tasman company policy provided support post-migration which was not available through government policy for the migrants who were considered sufficiently 'British-like' so as to not require settlement assistance. Tasman policy contributed significant capital through employment and other support mechanisms such as interest free housing loans. This allowed the migrants to build a capital base which was to provide advantages to future generations, and help them weather worsening economic conditions in future years through access to educational and employment opportunities. Economic capital was also provided by access to health and welfare assets supported by beneficial government health and social policy in both Finland and New Zealand. Tasman provided access to health assets as well, with a free doctor in the early years, health screening for employees, and later paid private health insurance. This post-migration capital built on the capital Gen1 had already accumulated in Finland; despite post-war conditions, Gen1 reported they had good jobs and lives in Finland where, for many, the company had also looked after them and their families with housing and access to health services. This capital influenced their decision to migrate, knowing they had the economic resources to return to Finland if they wanted to.

Migration policy in both countries provided cultural and social capital; Gen1 and 1.5 left a country where emigration was considered a norm, and arrived in a country where immigration was considered a norm by many, particularly in the multicultural town of Kawerau where they were welcomed as

‘desirable aliens’ and skilled workers. Again, Tasman company policy contributed more to the cultural competence of the migrants than government policy providing them with support such as English lessons, housing, furniture, materials to build a sauna and a familiar social stratification to that which they had known in Finland. The migrants themselves also developed significant social and cultural capital through the formal and informal structures of the Finnish Community, which supported them on settlement and also provided a sense of identity and belonging which was transferred to future generations. This capital transfer was found to be multidirectional in the field of migration, with Gen1.5 children taking on the role of ‘cultural ambassador’, exposing their parents to new ways of thinking and acting through their unique experiences with school, language and social situations post-migration. The notion of Finnish food created in the migrant context served as a key symbol of identity, belonging and health across generations. In this way, food was found to be a form of capital that was both accumulated and transmitted between generations through the subtle teachings of the seemingly mundane everyday embodied food experiences (Bourdieu, 1989, 1990b). Finally, the participants were able to access ‘body capital’. How the generations made sense of their genetic heritage and how this influenced their health practices supported the notion that people are embodied differently from birth, and that the body is not simply a carrier of habitus, but is worked on like other forms of capital (Meinert, 2004; Shilling, 1993; Wacquant, 1995).

The participants’ social practices were structured by their habitus, and they developed a ‘taste’ for what was available to them through their access to capitals. Their ‘practical logic’, borne of everyday practices, was ‘sedimented’ by past and present experiences across generations and through this they developed an embodied sense of their world and their place in it. However, their habitus was not static; their dispositions changed in response to migration and policy experiences and across generations as the participants acquired their ‘feel for the game’ in the fields of health and migration. Through a process of narrative ‘sense-making’ the participant group was found to have highly nuanced and layered lay models of health which they used to explain health maintenance, the reasons for good and ill health and to guide their health keeping practices. These understandings demonstrated how narrative can reveal understandings of health which do not necessarily reflect established policy definitions or models of health. Narratives also revealed that health and illness is more than a personal story of experience, it reflects wider life circumstances and experiences and how people make sense of these. The participant’s common-sense patterns of thinking and acting with regards to health appeared to be taken for granted by the group, and were influenced by their histories as well as public meta-narratives regarding what constitutes appropriate behaviour. Aspects of habitus were also found to be transferable between generations. This elucidated the reproducible and generative nature of habitus, providing

systematicity, coherence and consistency to the participants' practices (Bourdieu, 1990b) in the field of health. It also demonstrated the durable qualities of habitus and its "permanent capacity for invention" (Bourdieu, 2004, p. 63) allowing the potential for change and adaptation as everyday patterns and practices were sedimented across generations.

The research made extensive use of narrative, both as methodology (Chapter Two) and method (Chapter Three). Through narrative, participants in the study were able to make sense of their experience of health, giving it meaning and signification, within the wider economic, social, cultural and political contexts of their life experiences. Narrative as methodology was particularly suitable for this study given my 'intimate insider' status as stories emerged at times other than the formal interview process which allowed me to take advantage of a variety of data collection opportunities. Narrative as method allowed for deep probing of themes, revealing additional layers through a 'constructed' view and provided a useful contrast to the 'deconstructing' approach of the general inductive method. Narrative enabled discovery of how the participants' used their remembered pasts to make sense of their world and construct their identities, influencing their understandings and health keeping practices. Through narrative, people attempted to make sense of their lives in time through an interpretive framework; they remembered how and why things have happened in the past, they link that remembered past to their present, and they explored how this might shape their future. In this way, narrative allowed the participants to describe their lives in time; "...a life is not 'how it was' but how it is interpreted and reinterpreted, told and retold (Bruner, 1987, p 31). Stories were told in order to make sense of the experience, and the past and present were often reworked through the telling process.

The research also discovered the impact of appearing 'British-like' in policy, despite having a unique non-British migrant history. In the true Bourdieusian sense, it allowed for an exploration of health through the intersection of structure (policy) and meaning (interviews, observation, social interaction). The study found that even if people are categorised as 'white' or 'European' and appear physically 'British-like', their unique habitus and sense of identity and belonging may influence the way they think, act and feel about health in ways not predicted by policy or an arguably reductionist ethnic categorisation. This has implications for health policymaking and the provision of quality health care, particularly in New Zealand's multicultural context, where the 'medical gaze' of the various cultures of Western biomedical models may differ from the culturally-constructed lay models of health that are transferred across generations and influence the ways in which people seek health care, and whether they comply with medical advice.

9.3. Recommendations from the Study

This study concluded that the capitals provided by government and particularly company policy, resulted in significant resource and power advantages for the participants in the fields of migration and health. A recommendation from this study is that while macro-level migration policy continues to invite ‘desirable’ migrants to come to New Zealand, micro-level policies are required to provide the capital required for successful long-term health and settlement outcomes as evidenced by the generational experiences of the participants in this study.

The study recommends a move away from essentialising notions of culture, supported by ethnic categorisation, with the inherent dangers of stereotyping, to an understanding that migrant groups adapt and change over time and what is transferred to future generations also continues to adapt and change. Health professionals cannot achieve cultural competency by simply applying stereotypical approaches to people categorised by ethnicity. Rather, competency can be achieved by approaches that seek to reveal the multiple underlying factors that influence patterns of thinking and acting with regards to health, including the experience of being a migrant or a descendant of a migrant. This study found that even if people appear to be part of a homogenous ethnic group, they may have heterogeneous understandings of health, and these conceptions may influence their health keeping practices. The ‘medical gaze’ of the various cultures of Western biomedical models may differ from the culturally-constructed lay models of health that are transferred across generations and influence the ways in which people seek health care, and whether they comply with medical advice. A central idea in this thesis is that there is a difference between how health professionals view health (with all their biomedical diversity), and lay concepts of health. This difference could compromise care, affect health keeping, and may be able to be bridged through narrative. Most of the rituals and traditions of medicine and medical training are narrative in structure (i.e., case reports, anecdotes) and if the narrative structure of medicine is fully recognized by physicians, they will attend to their patients better and acknowledge the details and importance of their patients' individual life stories. Therefore, a recommendation from this study is for health professionals to consider that not all people who appear homogenous have similar lay models of health, and because health professionals and patients hold varying understandings about health and illness: “...patient and physician interpretations of disease are often quite dissimilar, and may affect the quality of care a patient receives” (Gregg & Saha, 2006b, p. 543). Therefore, the recommendation is for health professionals to engage in narrative designed to elicit the understandings of health of all patients (even those who do not appear ‘foreign born’), and not to rely solely on numerical information. As Lindemeyer and Griffiths (2010, p 2) proposed, this approach can improve compliance with medical advice resulting in positive outcomes for patients:

...discussions about family history in a health care context can be problematic. Health professionals may focus on extracting numerical information and side-line contextual narratives. For example, in consultations about heart disease, general practitioners may concentrate on the number of affected relatives and how old they were when diagnosed, avoiding engagement with patients about why they thought their relatives had heart disease (R. Hall, Saukko, Evans, Qureshi, & Humphries, 2007) ...The information they glean becomes part of decision making, such as the decision by the doctor to prescribe a statin to reduce cholesterol level in the blood and so reduce the risk of cardiovascular disease, while the patient's understanding of their family history may influence the decision to take the statin or not (Frich, Ose, Malterud, & Fugelli, 2006).

A further recommendation is for policy makers to consider an expansion of the New Zealand health policy discourse from the health needs of recent immigrants, based on ethnic categories and the inequalities agenda, to the idea that New Zealand is made up of generations of people, most with some degree of migrant history that may influence patterns of thinking and acting with regards to health. It raises a question about current health policy which is focused on those categorised as 'foreign born' who are perceived to have health needs / risks, or driven by the inequalities agenda which is predicated on, arguably inappropriately and somewhat homogeneously, statistical ethnic categories that may lose relevance over generations, as illustrated by the emergence of the New Zealander category. The participant group and their descendants are, in policy, a somewhat invisible white minority and have by and large been treated homogeneously in health policy and practice along with all others who appear 'British-like'. This is mostly as a result of the idea that white migrants would easily assimilate into the host society, and would therefore not need any special consideration in policy or practice. However, this was based on: "over simplistic culturalist explanations" (Mason, 2000, p. 93) that assumed all migrants who looked 'British-like' would think, feel and act 'British-like' within a short period of time in New Zealand. Given the current focus on eliminating health disparities based on a somewhat reductionist categorisation of ethnicity, this study raises a question about whether Gen1 and 1.5 in particular (and other Gen1 and 1.5's from other groups in New Zealand) may suffer from the assumption that people in the arguably heterogeneous European or 'mainstream' category do not require any specific health policy consideration, and that through this their capitals may be reduced. This consideration may be particularly acute for our aging population when language and other competencies are threatened.

A future research agenda also emerges from this study. Immigrant populations are diverse, and future generations even more so, and therefore: "...generalising about 'immigrant health' is problematic, a serious exploration of this subject requires nuanced assessments of particular histories and social locations" (Sargent & Larchanche, 2011, p. 347). Given that lay conceptions of health can help to address public health problems and health inequalities (Popay et al., 2003; Popay & Williams, 1996; Popay, Williams, Thomas, & Gatrell, 1998), there may be useful things to learn from the nuanced health and migration experiences of European non-Anglo Celtic migrants and their descendants in New Zealand, a somewhat silent and undifferentiated minority in both policy and research. In particular, there may be useful things to learn from these groups about the nature of successful settlement and why some within the statistical European ethnic category appear to experience better health outcomes than other groupings, such as those categorised Maori, Pacific or Asian. Therefore, a recommendation from this study is that further research on the generational migration and health experiences of European non-Anglo Celtic groups be undertaken in New Zealand.

Appendices

Appendix One - Finns and Finland

The Finns are an ancient people with cultural relics dating back to 8000 BC and their defining characteristic is 'sisu' – grit and guts. Strength has grown from perseverance under harsh conditions, war, and centuries of endurance under foreign masters. Sisu knows no gender boundaries, with women and men standing side by side through history to turn forestland into fields in some of the most unforgiving climactic conditions in the world, one tree and one stone at a time (Encyclopædia Britannica Online; Solsten & Meditz, 1988; Visit Finland).

Suomi (Finland) is about as far north in the world as it is possible to go. The climate is severe with temperatures falling to as low as minus 30 degrees Celsius in the north. Winter is the longest season in Finland with the polar night lasting for more than 50 days north of the Arctic Circle. During the short summer in the north, temperatures can reach more than 27 degrees Celsius and around two months of midnight sun is experienced where the sun does not set. The extremes of climate are less severe in the south thanks to the warming influence of the Baltic Sea and Gulf Stream-warmed airflow from the Atlantic. Finland shares borders with Sweden, Norway and Russia, and across the Gulf of Finland lies Estonia. The landscape is one of vast forests, lakes and Europe's largest archipelago. Almost 70% of the country is covered by forest and there are approximately 188,000 lakes which equates to around 10% of the total area of Finland. There are around 180,000 islands and 35 national parks. Pine, spruce and birch are the most common tree species and wild mushrooms, berries, fish and rye bread are essential elements of the Finnish diet (Encyclopædia Britannica Online; Solsten & Meditz, 1988; Visit Finland). The natural world, as the true home of the Finn, is expressed through the arts. The Kalevala³⁸, Finland's national epic folk poem which draws inspiration from the natural landscape, has been said to have stirred the flames of independence and is a politically significant symbol of national culture (Siikala, 2006).

In 1950 the population was relatively sparse at approximately 4 million people, even with the 1947 baby boom of an average of 3.5 births per woman. The population was almost evenly distributed between men and women (Population Register Center; Statistics Finland; Statistics Finland). The two constitutionally determined national languages of Finland were Suomen kieli (literally Finnish tongue) and Ruotsin kieli (literally Swedish tongue). Speaking the Finnish language had strong links to feelings of nationhood and independence, and in 1950 91.10% of the population spoke Finnish as their primary language (Statistics Finland). The nationalistic adherence to a pure Finnish language likely had its roots in history. In 1850 the Finnish language ordinance prohibited the publication of Finnish books, other than for religious or economic purposes. All other publications including literature, academic and administrative/government were in Swedish. It took until 1902 for Finnish to be accepted as a national language, along with Swedish. Unlike most European languages – including English which belongs to the Indo-European family - Finnish, Hungarian and Estonian belong to the Finno-Ugrian group of languages. Finnish has a reputation as a difficult language and it is estimated that between 65-70% of Finnish

38 Elias Lönnrot's process for developing The Kalevala set the methodological and theoretical foundations for Finnish folklore studies. Lönnrot engaged in field work to collect folk poetry and created a single literary work.

words are compounds, reflecting the Finns' propensity for less small talk and more straightforward and short communications which are often loaded with meaning (Encyclopædia Britannica Online; Solsten & Meditz, 1988; Visit Finland).

Distinct regional dialects and stereotypes were a feature of life in Finland, and still persist today. For example, the Karjalaiset were considered talkative by nature. The most common groups were the Savolainen, Karjalainen, Hämmäläinen, and Pohjolainen (from the Savo, Karjala, Häme, and Ostrobothnia regions). While Finland is a single nation, by tradition Finns think of themselves as belonging to one of four tribes - Pohjola, Savo, Karjala or Häme. People from Pohjola are considered straightforward and pugnacious, and the Savolaiset are thought of as good storytellers who are shrewd, quick and playful. The Hämmäläiset are described as slow and taciturn (Visit Finland).

In the 1950s Finland was, and still is, arguably one of the most ethnically, religiously and culturally homogenous countries in Europe with less than 2% of the population identified as non-Finnish (Statistics Finland; Visit Finland). Hundreds of thousands of Finns emigrated after the Second World War, mostly to Sweden, and emigration continued to exceed immigration right up until the 1990s due to restrictive immigration policies (Encyclopædia Britannica Online; Solsten & Meditz, 1988). In 1950, 95% of the population identified as Lutheran (Statistics Finland; Visit Finland) and the church records in Finland and Sweden are among the oldest population records in Europe with records of births, marriages and deaths being kept by the church from 1628. By 1686 the maintenance of parish registers became the law of the land under the Church Act. If your name was not recorded in the 'church book' then you did not exist under law. In addition, there was a list of first names permitted by the church that you could choose from to name your child. If you chose a name outside this list, you were not able to have your child recorded in the 'church book'. Each name has a dedicated name day on the Finnish calendar which is celebrated similar to a birthday celebration. The tradition of celebrating a name day is still practiced in Finland today and is often thought of as more important than the celebration of a birthday (Encyclopædia Britannica Online; Solsten & Meditz, 1988; Visit Finland).

Finland in the 1950s was highly nationalistic and the Finns possessed a unique national identity (Visit Finland). Finnish design in glass, textiles and porcelain became internationally recognised after the Second World War (Visit Finland). Modern consumer goods were readily available and Finns would buy their pulla (sweet Finnish coffee bread) and clothes ready-made from the shops. Some of this highly nationalistic identity may have developed from the Finns having survived centuries of religious and economic wars, crusades, and various foreign invaders. Finland was under Swedish rule for 600 years until 1809, and then under Russian rule for just over 100 years. After many years of struggle, Independence was finally achieved peacefully from the Russian Empire on 6th December 1917. The following internal conflict between the revolutionary Reds and the right-wing government was bitter however, with approximately 30,000 lives lost in the Finnish civil war. Itsenäisyyspäivä (Independence Day) is still celebrated as a national public holiday with state and local festivities (Encyclopædia Britannica Online; Solsten & Meditz, 1988).

Post-Independence, Finland's main threat to security came from the Soviet Union and despite a 1932 Finnish-Soviet non-aggression pact they remained wary and mistrustful neighbours. The Soviet Union were concerned about threats to their border by other countries using Finland to gain passage, particularly because of Finland's proximity to Leningrad / St. Petersburg. Finland was concerned about the threat to their independence by their giant neighbour. By October 1939 the Second World War was underway with Germany's defeat of Poland. The Soviet Union, wanting to protect Leningrad from German attack, demanded that neutral Finland cede a part of the Karelian Isthmus, a naval base at Hanko, and some islands in the Gulf of Finland so the Soviets could establish air bases. By the end of November 1939, diplomatic relations had broken down with Finland refusing to cede territory. Without declaring war, the Soviet Union launched attacks on Finland by land and air and the Winter War began on 30th November 1939. Finland mounted a courageous resistance despite the overwhelming war resources of the Soviets, and little help from allies. The Soviets underestimated the Finns' 'sisu' – the powerful combination of determination, perseverance and mental toughness that mobilised the country to fend off the invading Goliath. Despite the Finns bravery and many successful defence actions, they were eventually overwhelmed by the sheer numbers and resources of the Soviets. In total, 25,000 Finnish troops and civilians were killed and 45,000 were wounded. The Soviets lost more than 200,000 troops and sustained an unknown number of casualties (Encyclopædia Britannica Online; Solsten & Meditz, 1988; Visit Finland; World War 2 Net Timeline).

After more than three months of bitter fighting, a peace treaty was agreed and on 13th March 1940 the Winter War ended. The terms of the Treaty of Moscow were harsh for Finland - a large area of south-eastern Finland including Viipuri was ceded to the Soviets, and there was agreement to lease the Hanko peninsular for 30 years. Finland secretly planned to recapture their lost territory and by mid-June 1941 Finland had begun a mobilisation of its forces. While there was no formal agreement, Finland allowed the transit of German troops on its territory in order to weaken the enemy. On June 22nd 1941 while Germany attacked the Soviet Union, Finland commenced the War of Continuation to recapture lost territory and to advance on Leningrad. History records that while the Finns wanted their own territory returned, their heart was not for taking Leningrad and there was a growing desire for peace. Although Finland achieved some early successes, ultimately the War of Continuation ended with an armistice on 19th September 1944 on the condition that Finland recognise the 1940 Treaty of Moscow as well as cede Petsamo and lease an area near Porkkala to the Soviets for 50 years, in place of the previous Hangö agreement (Armstrong, 2004). In total, around 10% of Finland's territory was lost. In addition all foreign – German – forces were to be evacuated and the equivalent of \$300 million was to be paid in goods to the Soviets as war reparations within six years. The Germans did not leave willingly and in their retreat they destroyed large areas of northern Finland, bombing and burning in their wake (Encyclopædia Britannica Online; Solsten & Meditz, 1988; Visit Finland; World War 2 Net Timeline).

Gen1 were affected in one way or another by war. My Mummu told me that in her hometown of Kemi the Germans rounded up civilians into the school while they blew up the town hall. As they left Kemi, they blew up the bridge over the Kemijoki river. Kemijoki, the longest river in Finland at 550kms, runs through Kemijärvi and Rovaniemi before reaching the Gulf of Bothnia at Kemi. In 1946 the first hydroelectric power plant was

built on Kemijoki at Isohaara, and instead of a new bridge, a dam was built on the river at Kemi to support the power plant. My Pappa's mother owned an island and sea area off the waters of Kemi. At that time, it was possible to own land and parts of the sea area including customary fishing rights. The sea area provided a plentiful and lucrative fishing ground for Baltic salmon. The dam prevented the salmon from reaching their spawning grounds and so my Pappa's family's livelihood was significantly affected. The search for a new livelihood was a primary motivation for Mummu and Pappa's decision to emigrate to New Zealand.

Post-war to modern times saw a shift in the Finnish-Soviet relationship from uneasy neighbours to the foreign policy Agreement of Friendship, Cooperation and Mutual Assistance signed in 1948 and extended in 1955, 1970 and 1983. While the relationship was not entirely uncomplicated and some restrictions were placed on Finland, peace and trade have endured. After war reparations had been paid, trade with the Soviet Union continued to increase rising to around 25% of Finland's total exports in the 1980s. The Soviets honoured the terms of the peace treaty, returning the base at Porkkala in 1955 (Encyclopædia Britannica Online; Solsten & Meditz, 1988; Visit Finland).

Between the two world wars Finland was considered primarily an agrarian country – about 70% of the population was employed in agriculture and forestry in 1918. By 1940 this was still as high as 57% with paper and wooden products still Finland's leading export items. Domestic economic struggle marked the post-war years with the challenges of rebuilding, war reparations and the absorption of approximately 300,000 Finnish refugees from the ceded territories. The post-war economy consisted mainly of forestry, mining and agriculture. Finland rose to these challenges and quickly recovered through rapid industrial expansion in the metal, shipbuilding and timber industries boosting exports beyond pre-war levels (Encyclopædia Britannica Online; Solsten & Meditz, 1988; Visit Finland).

The nuclear family was, and still is, the focus for Finns. Many traditional Finnish social customs emerged from forest life, and many of these traditions endure both in Finland and in the three generations of this study. Bonfires are lit at Midsummer, the doorways of houses are decorated with birches, and leafy birch whisks are still used in the traditional wooden sauna. On Easter, mämmi, a pudding made from malt and rye flour, is traditionally eaten from containers made of (or made to resemble) birch bark. In late winter, while snow covers the ground, birch branches are brought indoors to remind the household of the coming spring. Although Finns consider Santa Claus to have his permanent home in Korvatunturi, in northern Finland, the spruce Christmas tree is a relative newcomer to the country, having made its first appearance in the 1820s. Now the Christmas tree is a fixture of Finnish Christmas celebrations, which also involve special foods, including rice porridge (made with milk and cinnamon), cold fruit compote, a baked glazed ham, and a potato and carrot or rutabaga gratin (Encyclopædia Britannica Online; Visit Finland).

Christmas is a very important festive and family time of the year with the main event taking place on December 24th – Christmas Eve – when a traditional family dinner is eaten and gifts are exchanged. Some of the Christmas dishes date back to the 18th century. Other Christmas traditions include: taking sauna, making a gingerbread

house, visiting the cemetery to place candles on the graves of loved ones, attending church, and a local Joulu Pukki (Father Christmas) visiting houses. The public holiday of Epiphany or Twelfth Night on January 6th marks the end of the festive season. This is the day that the Christmas tree and decorations are taken down and life returns to normal. Some Finnish celebrations are a curious mix of Christian and old Finnish religious traditions. Midsummer is celebrated when the sun barely sets in the South; in the North it does not set at all. Juhannus (Midsummer) is a public holiday where the feast day of St John the Baptist is celebrated on a weekend closest to the summer solstice (June 21st), generally with the kokko (Midsummer bonfire) and other festivities rooted in old Finnish religious traditions. Easter celebrates the resurrection of Christ and is a welcome to a tentative Spring. As a remnant of Finnish religion, children dress as witches and go door to door reciting charms and accepting gifts of money and lollies (Encyclopædia Britannica Online; Visit Finland).



Figure 22 I am on the left heading out to the neighbourhood houses in Finland at Eastertime

Holiday celebrations are not complete without a sauna bath. Wood is an essential component of the typical Finnish sauna, which is almost universally constructed out of birch or other sturdy wood beams. Bathers sit on wooden benches, splashing water on the hot stones of the stove and whisking each other with birch branches, just as their ancestors would have done millennia earlier. Traditionally, the sauna was a sacred place for the Finns, used not only for the weekly sauna bath but also for ritual purposes. This was particularly the case for those rituals performed by women, such as healing the sick and preparing the dead for burial (Encyclopædia Britannica Online; Visit Finland). Urban (2008, p. 1) commented that traditionally the: “Finnish sauna was used for bathing, healing, and even as a sanctified environment for birthing and preparing the dead for burial. The Finns strongly believed that saunas were a therapeutic cure-all for any ailments or maladies” and that:

Historically, Finnish women gave birth to their babies in saunas, and then remained contained in the sauna with their newborn for several days after the delivery. Saunas were considered hygienic, sacred environments, ideal for conducting some of life's most vital rites and ceremonies

Brooke (2003, p. 1) stated that: “Without exception it was the women who performed all the life-cycle rituals in the sauna” and that these traditions persisted in many areas up until the Second World War when much of the country was agrarian and saunas were an essential part of farming life. The sauna was also used for doing laundry and for key farming activities, such as curing meat and fermenting and drying malt. Given its importance to the farm economy, it is logical that the sauna was originally built within the enclosure surrounding the farm's outbuildings. The current placement of most saunas on a lakeside or coastal inlet goes back only to the early 20th century, following the fashion of the gentry's villas. For a long time the sauna (whose name comes from a Finnish-Sami word) was usually heated only once a week, because it took a whole day to prepare it by specially knowledgeable and experienced people. A number of texts report that men and women traditionally bathed separately, but my Pappa told me that he remembers men and women always bathing together in family groups. Finnish sauna was and still is a ritual, an institution, and an essential element of the Finnish way of life and it is estimated that there are more saunas than cars in Finland. The traditional sauna is wood-burning and closely located to a jetty that stretches out on to a lake for the after-sauna cooling dip and a picturesque summer spot for a cool drink. Or, in winter, the after-sauna dip is through a hole in the ice and then back into the sauna to warm up. There should also be plenty of birch trees nearby, both to burn to heat the sauna and to slap the skin with the twigs to stimulate circulation. Water should be splashed on to hot stones to achieve the perfect quality of löyly (steam) (Encyclopædia Britannica Online; Visit Finland). Modern sauna rituals include attending sauna for the purposes of business meetings or to hold political discussions. Urban (2008, p. 1) proposed that Finns believe: “...the tranquil, stress-free environment of a sauna makes it ideal for the exchange of ideas and the bartering of deals”.

Appendix Three – Interview Documentation

Reference Number: 2007/415

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PARTICIPANT INFORMATION SHEET

RESEARCH ON EXPERIENTIAL HEALTH KNOWLEDGE FROM THE PERSPECTIVE OF A FINNISH MIGRANT GROUP

What is the rationale for this research?

This research was born out of my personal interest and experience of being the daughter of a Finnish migrant (see my family connections at the end of this Sheet). Pursuing a doctorate in Public Health and working in management of service provision at a District Health Board focused this interest on pursuing a health topic in relation to a Finnish migrant group. The rationale for this research is to discover and understand how the unique migrant group that you are a part of, understand health. In particular, how being part of a migrant group impacts your understanding of health, and discovering if there are differences in how three generations of migrant Finns understand health.

In addition to academic supervisors, who else has helped in the development of this research?

I have enlisted support from the following people in defining the research purposes and scope.

- Paavo Sandberg (my maternal grandfather). Acting in an advisory capacity and will also provide first generation translation and assistance with participant and interviewee identification.
- Hannele van der Molen (my mother). Acting in an advisory capacity and will also provide first generation translation and assistance with participant and interviewee identification.
- Jason Viitakangas (my cousin). Acting in an advisory capacity and will also provide assistance with participant and interviewee identification.
- Olavi Koivukangas, Director, Institute of Migratory Studies, Turku, Finland. Acting in an advisory capacity.

Who are the participants in this research?

The aim is to interview up to 30 first, second or third generation Finnish migrants. Participants will be English-speaking (first or second language) men or women between the ages of 18 and 90, currently living in the Bay of Plenty, who meet one of the following criteria:

1. First generation – adults who were part of the original group of Finnish families that migrated to Kawerau to staff the Tasman mill between 1954 and 1962.
2. Second generation – biological children of the first generation group that were either part of the original group of Finns that migrated to Kawerau, or, were born in New Zealand.
3. Third generation – children of the second generation group who were born in New Zealand.

You have been identified as a possible participant as you meet one of the above criteria. You were identified by one of the three advisors to this research project - Paavo Sandberg (first generation Finn), Hannele van der Molen (second generation Finn), and Jason Viitakangas (third generation Finn). Your name, or family name, is also published in Koivukangas' Register of migrants, which was compiled from immigration files (New Zealand Immigration Service). (*Koivukangas, 1996, pp374-397*).

In addition, up to 5 non-Finnish participants who had frequent interactions with the first generation migrant group between 1953 and 1963 will be interviewed. This is so their recollections of their experiences with the Finns can be documented to provide some historical context to the first generation migrant experience.

How much time will you need to commit to this research?

I estimate that you will need to commit six hours to this research including: our initial meeting, reading the documentation (i.e., this Sheet and attachments), searching for any photos/documents you may like to share, answering the Questionnaire, the Interview, reviewing the Interview transcript if desired, attending the oral presentation and reading the final research report.

How will the information you share be treated?

Information will be gathered by written Questionnaire and at the Interview. Your answers to the Questionnaire will be written by me at the Interview, and the remaining part of the Interview will be audio-taped. Audio tapes for use during the research will be stored in a locked filing cabinet at my house. Once the tapes have been transcribed they will be recorded over or destroyed. Electronic data used during the research will be stored on a secure server (Bay of Plenty District Health Board password and firewall protected), and backup copies of all data will be made on memory stick. The memory stick will be stored in a locked filing cabinet at my house for six years. During the research and after the research has been completed, all electronic data or printed material will be held for six years in a locked filing cabinet at my house. All identifying materials (including key words or codenames) will be stored separately from the coded data in electronic form on my personal computer (password and firewall protected). The reason I will keep the information for six years is to allow for the option of pursuing further research utilising this data, for example publishing part of the research in a journal. After six years all information will be destroyed.

How and when will the research be reported?

The research will be reported in thesis form to the University of Auckland as a doctoral thesis for a Doctor of Philosophy. I commenced this programme October 2007 and expect to complete it by October 2010. Advisors to the research and three selected participants will be requested to read the initial drafts and suggest revisions. Following acceptance of the thesis from the University of Auckland, a brief summary report will be sent to interested parties within two months. Participants and advisors will be sent a copy of the summary report and the thesis (final research report) within two months. An oral presentation will be prepared at the end of the project and participants and interested stakeholders will be invited to attend. The presentation will be scheduled within three months of acceptance of the thesis from the University of Auckland. This will give an opportunity to ask questions about the research and the findings.

<i>Stakeholder</i>	<i>Distribution</i>
Institute of Migration / Olavi Koivukangas	Summary Report
Participants	Summary Report, Thesis, Oral Presentation
Participants' families and wider Finnish community	Oral presentation
Advisors to the project	Summary Report, Thesis, Oral Presentation
University of Auckland advisors / supervisor	Summary Report, Thesis, Oral Presentation

What if you change your mind about being involved?

You have the right to withdraw from the research at any time. Once the Questionnaire and Interview have been completed, you have four weeks to withdraw any data that can be traced back to you as the source. During the four week period after the Interview I will be transcribing the data and I will start the analysis of the data. It will then become part of the research, making it impossible to separate from other interview data.

Why does the Interview need to be audio-taped?

The Interview process is an opportunity for you to talk in an open and unstructured way about your experiences. If I had to try and take notes during this process I would not be able to capture all the information in the same way that an audio-tape can. After the Interview I will transcribe everything you said so I can analyse it in detail. You will have the option of reviewing this transcript to check for accuracy. If you take up this option, I will post a copy of the transcript to you within two weeks of the Interview. I'll get in touch with you by phone a week later to see if you have any suggestions to improve the accuracy of the transcription. You will not have access to the audio-tape as these will be recorded over or destroyed after the Interview has been transcribed. Also, they are small analogue tapes that can't be played back in a conventional cassette recorder.

Translation from Finnish to English

While the Interview will be conducted in English, you may want to use some Finnish words to describe your experiences. If this happens, we will work together to note an English translation.

My reason for not giving an option of conducting the interview process in Finnish is due to my Finnish language ability. While I have a good understanding of conversational spoken Finnish, my speaking and writing is not fluent.

Confidentiality

I will do my utmost to ensure your participation in the research and your information will be anonymised (in terms of the extent allowed by law). Your name will not appear on the Questionnaire or Interview transcript (these will be coded), or on the final report. However, if you would like to have your name appended to the research report, please note this on the Consent Form where indicated. While no specific comments will be attributed to you in the report, you have the option of being recorded as a participant in the research. Even though I won't use your name unless you give me permission to do so, there is a possibility that you could be identified in the final report. This is because the participant group is small, known locally and known to each other. While care will be taken to report information in such a way as to protect the identity of all participants, given the nature of the participant group this cannot be guaranteed. In any case, if any information you provide is reported/published, this will be done in a way that does not identify you as its source.

If during the research process you provide information that reveals a reasonable possibility that the life or health of any person may be at serious risk, then I have a moral and legal obligation to breach confidentiality and report that risk to the appropriate authorities and appropriate others.

What happens if the Interview process upsets you?

Thinking and talking about the past and issues around health, may cause discomfort or upset. If this happens, I will assist you to access support from friends or family, or to seek assistance from a health professional if appropriate. If during the course of the interview you disclose a health condition, I will assist you to refer to the appropriate health professional.

In addition, Sister Meg Hills, has offered to support you if required. Sister Meg is a qualified Social Worker and Grief & Loss Counsellor. She works at Whakatane Hospital and can be contacted on **306 0898**. There would be no cost to you for this support.

Funding for this research

I have received funding from the University of Auckland PrESS account for this research.

Contact Details

Researcher

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For any queries regarding ethical concern you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland 1142. Phone: (09) 373 7599 ext. 87830.

Researcher's Family Connections (excludes family members by marriage)

Paavo and Toini Sandberg (nee Viitakangas) migrated to Kawerau in 1959 with their two children, Hannele and Maria. Hannele had two children, Kerrie (the Researcher) and Kristie. Maria adopted one child, Sara. Paavo's family did not migrate. Toini had four brothers and one sister. One brother, Kaarlo, migrated to Kawerau in 1954, five years before Paavo and Toini. Kaarlo was instrumental in Paavo and Toini's decision to migrate. Another brother, Vilho, and Toini's sister Raili (known as Kyllikki), migrated to Kawerau two years after Paavo and Toini. Toini's sister moved from New Zealand to Australia after five years. Kaarlo had two children – Raija and Rauli. Raija had two children – Maxine and Tony. Rauli had one child, Lena. Vilho had four children - Timo, Jouni, Esko, and Hannu. Timo had three children – David, Jason and Nadia. Jouni had three children – Selina, Tammy, and Jaana. Esko had one child, Aaron. Hannu had two children – Simon and Zans.

CONFIDENTIALITY AGREEMENT (TRANSLATORS)

This Confidentiality Agreement will be stored securely for six years by the Researcher at the Researcher's residence

Study Title: Research on experiential health knowledge from the perspective of a Finnish migrant group.

CONFIDENTIALITY AGREEMENT Between

[NAME]

[ADDRESS]

[ADDRESS]

Hereafter referred to as 'Translator'

And

Kerrie Freeman

School of Population Health

University of Auckland

Private Bag 92019

Auckland.

Phone: Day (07) 306 0770 A/H (07) 322 2936, Mobile 021 221 6201

Email: Kerrie.Freeman@bopdhb.govt.nz

Hereafter referred to as 'Researcher'

The Researcher will:

- 1 Provide confidential information to the Translator for the purposes of translating from Finnish to English.
- 2 Provide confidential information in audio form by allowing the Translator to listen to portions of audio-taped interviews.
- 3 Not divulge any information that may reveal the identity of the person who has been audio-taped.
- 4 Not divulge any audio-taped content other than that absolutely necessary for the purposes of accurate translation.

The Translator agrees to:

- 1 Provide accurate translation services from Finnish to English to the best of their ability.
- 2 Keep all research information confidential by not discussing or sharing the information in any form or format with anyone other than the Researcher, now or in the future.
- 3 Return all translation information in any form or format (i.e., handwritten notes) to the Researcher when the translation tasks have been completed.
- 4 Not duplicate any audio-tape.
- 5 Delete any text recorded on the Translator's personal computer connected with the Translation tasks.

I _____ (Translator print full name)
agree to provide confidential translation services for the research as outlined above

Signed: _____
Translator

Date: _____

CONSENT FORM (PARTICIPANT)

This Consent Form will be stored securely for six years on Auckland University premises by the Supervisor of this research

Study Title:

Research on how the health knowledge of a Finnish migrant community has developed and changed in the contexts of: migration, culture contact, policy and multigenerational transfer.

Researcher:

Kerrie Leann Freeman, School of Population Health, University of Auckland, Private Bag 92019, Auckland.
Phone: Day (07) 306 0770 A/H (07) 322 2936, Mobile 021 221 6201
Email: Kerrie.Freeman@bopdhb.govt.nz

I have read and understood the Participant Information Sheet and attached documentation for this study. I understand the nature of this research and why I have been selected. I have had the opportunity to ask questions and have had them answered to my satisfaction.

I understand that all information and data on this research will be stored securely at the Researcher's residence for six years to allow for any further work that may be undertaken using this information.

I understand that my participation in this study is voluntary and I may withdraw from the study at any time without offering a reason. I may also withdraw any information provided that can be traced back to me as the source up until four weeks after the Interview.

I understand that the Interview with me will be recorded and I agree to the audio-tape recording of the Interview, understanding that the copies of the tapes will be kept in a locked cabinet prior to transcription. Once the Interview has been transcribed and checked for accuracy, the tapes will be recorded over or destroyed.

I understand that while care will be taken to report information in such a way as to protect the identity of all participants, given the nature of the participant group this cannot be guaranteed.

I **would / would not** like the opportunity to review a transcript of the Interview for the purposes of noting any issues of inaccuracy (circle preference).

I **would / would not** like my name recorded as a participant in the final research report (circle preference).

I **agree / do not agree** for any documents or photos provided by me (as listed below) to be recorded in the final research report and future publications (circle preference).

I _____ (Print full name)
agree to take part in this research

Signed: _____

Date: _____

Documents and Photos

INTERVIEW SCHEDULE (PARTICIPANTS)

To be used as a guide by the Researcher at Interview

RESEARCH ON EXPERIENTIAL HEALTH KNOWLEDGE FROM THE PERSPECTIVE OF A FINNISH MIGRANT GROUP

Health, attitudes, beliefs, values

- 1 How do you define health?
Mitä terveys tarkoittaa sinulle?
- 2 What do you think contributes to a good health / what do you do to maintain your health?
Minkä luulet edistävän hyvää terveyttä / miten toimit pysyäksesi terveenä?
- 3 What do you think causes ill health / how do you deal with ill health and not feeling well?
Mikä mielestäsi aiheuttaa sairauksia / miten toimit sairauden tapahtuessa, tai tuntiessasi itsesi huono kuntoiseksi?
- 4 Do you consider yourself healthy - why / why not?
Oletatko olevasi terve - miksi / miksi et?

Migration experience

- 1 Tell me about your experience of migrating from Finland.
Kerro minulle kokemuksistasi Suomalaisena siirtolaisena.

Prompts for migrants born in Finland: what differences did you notice between life in Finland and life in NZ when you migrated?

Lyhyesti ensimmäisen ja toisenpolven Suomalainen siirtolaisena Uudessa Seelannissa: Millaisia erilaisuuksia huomioit alkuajoina entisen kotimaan ja uuden välillä?

- 2 In what ways do you identify as being a New Zealander? (customs, traditions, food, childhood memories, language, dealing with death and dying, contact with New Zealand family / friends)
Millä tavoin tunnistat olevasi Uusi Seelantilainen? (tavat, perinteet, ruoka, lapsuuden muistot, kieli, toiminta kuoleman tapauksessa tai kuolevaan suhtautuminen , yhteys Uuden Seelannin perheen / ystävien kanssa)
- 3 In what ways do you identify as being a Finn? (customs, traditions, food, childhood memories, language, dealing with death and dying, contact with Finnish family / friends).
Millä tavoin tunnistat olevasi Suomalainen? (tavat, perinteet, ruoka, lapsuuden muistot, kieli, toimiesä kuolevan kanssa tai kuoleman sattuessa yhteys Suomalaiseen perheeseen /ystäviin)
- 4 Do you think you would feel at home if you moved back to Finland to live now?
Jos muuttaisit takaisin Suomeen,luuletko että voisit vielä kotiutua sinne?.

General

- 1 Is there anything else you would like to say about your perspective on health, as a Finn in New Zealand?
Olisiko muuta jota haluaisit sanoa ,mikä on sinun näkemys terveydestä Suomalaisena Uudessa Seelannissa?

QUESTIONNAIRE (PARTICIPANTS)

To be administered by the Researcher at Interview

Researcher will ask the questions and fill in the Questionnaire

RESEARCH ON EXPERIENTIAL HEALTH KNOWLEDGE FROM THE PERSPECTIVE OF A FINNISH MIGRANT GROUP

ID

M / F

Date of birth / /

First / Second / Third generation migrant

Country of birth

If Finland, where in Finland (town/province) were you born?

If Finland, where in Finland (town/province) did you spend most of your childhood?

If New Zealand, where in New Zealand (town) were you born?

If New Zealand, where in New Zealand (town) did you spend most of your childhood?

Marital status: Single / Married / Widow / Widower / _____

If participant has been married, ethnicity of spouse _____

Which ethnic group(s) do you identify with?

Do you identify as being part of a religious group? If yes, which one(s)?

Number of children (if any)

Highest educational achievement

Most recent occupation (last job you had)

Current employment status: Employed / Unemployed / Retired / Beneficiary / _____

Primary ethnicity of mother

Primary ethnicity of father

What is your first language?

Do you speak Finnish? Yes / No

If yes, on a scale of 1 to 5 (5 being fluent) where do you rate your ability? 1 2 3 4 5

Do you understand spoken Finnish? Yes / No

If yes, on a scale of 1 to 5 (5 being fluent) where do you rate your ability? 1 2 3 4 5

Can you read Finnish? Yes / No

If yes, on a scale of 1 to 5 (5 being fluent) where do you rate your ability? 1 2 3 4 5

Approximately how many years have you lived in Finland over your lifetime?

Approximately how many years have you lived in New Zealand over your lifetime?

Approximately how many years have you lived in Kawerau over your lifetime?

Approximately how many years have you lived in a country other than Finland or New Zealand over your lifetime?

Would you please complete a family chart from the point of migration?

COVERING LETTER

Dear [NAME]

RESEARCH ON EXPERIENTIAL HEALTH KNOWLEDGE, FROM THE PERSPECTIVE OF A FINNISH MIGRANT GROUP

Thank you for considering participation in this research project.

The research will focus on the experiences of participants that shape health attitudes, beliefs and values. This will include understanding how being a Finnish migrant has shaped your experiences and understandings of health. The information will be gathered through a short Questionnaire and an Interview with me.

Benefits of participating in this research include an opportunity for you to explore thinking around health issues, and to have your unique experiences recorded and published. This research will be published as a doctoral thesis. I am enrolled as a doctoral student at the School of Population Health, Auckland University.

The attached Participant Information Sheet aims to provide you with the information you need to make a decision about whether or not to be part of this research.

Also attached are:

1. The Questionnaire that will be completed at the Interview
2. The Interview Schedule of questions for your information
3. A Consent Form – your written consent is required prior to the Interview taking place

Finally, would you please consider sharing any relevant documents or photos you may have during the Interview, or, to be used in the final research report?

Please do not hesitate to contact me should you require further information.

Yours sincerely

Kerrie Freeman
Researcher

Encl.

Appendix Four - Toivo's Story

Toivo Nurkka, one of the Finnish men recruited to the Tasman mill in Kawerau, documented aspects of the preparation to travel to New Zealand in a diary³⁹, commencing with the move of some Finnish mill colleagues to Tokoroa, and one year later, the Nurkka family's move to New Zealand. Little did Toivo know in May 1953 when he farewelled his friend Pauli that he would end up having a lifelong friendship with him on the other side of the world. The diary style represents the typical Finnish man's penchant for short, direct communications.

APRIL 1953

- 2 Skates bought for Osmo from Lajunen's for 1500 mks. Lajunen's emigrating to New Zealand
- 23 Families moving to New Zealand sent their packing crates on ahead. ie. Lajunen, Reinikkala, Myllärinen and some others.
- 24 Lajunen's cleared their apartment
- 29 Pauli Lajunen worked his last night shift

MAY 1953

- 3 Lajunen's farewell party. Singing, photos taken
- 5 Travellers to NZ left on the Vilkkala Line bus. Aino Tohka left as well
- 11 Postcard from Lajunen's

MAY 1954

- 22 Received application papers for New Zealand
- 27 Passport photos taken
- 31 X-rayed as a part of medical clearance. Received the official clearance.
Very dry month

JUNE 1954

- 1 Fluoroscopy at Kotka
- 2 Copy of Police records
- 3 Aili, Marjatta, Matti and Vesa went to doctors for medical check
- 4 Kalevi, Osmo and I went for ours. Medical certificates clear
- 7 Form 303 completed and sent off
- 9 Passports arrived
- 12 Papers sent away... 160 mks
- 15 Work contract received. Filled in and sent back 56 mks
- 20 Thunder storms
- 23 Warm morning. Midsummer bonfire at Kesäniemi. Windy and cool.
Cargo allowance 20 cu. ft. per adult ticket, 10 cu. ft. per half fare

³⁹ Diary translated from Finnish to English by Toivo's son and daughter-in-law

JULY 1954

- 1 Sent form 303 away again to A. Marks, Tasman Pulp and Paper Co Ltd, 17 Gromwell Place, London, S.W. 7., England
- 7 Received a letter from Lajunen's [NZ]. Warm day
- 11 Antti and Sirkka came to visit. Heavy thunder storm
- 13 They left
- 16 Received letter of travel plans etc.
- 19 Sauna at Elomaa's
- 21 Warm day. Going to Kuivala
- 27 Sauna at Aalto's
- 28 Bought a Banjo-Mandolin for 12,000 mks
- 29 Sauna at Lipiäinen's
- 30 At Hevosoja. Went berry picking and to the lake

AUGUST 1954

- 1 - 5 Visiting relatives at Mäenpää [Pyöriä], Niveri, Tohka, Liila and Pyötsiä's.
- 6 Back home
- 7 Last day of summer holiday
- 8 Lipiäinen's visiting, [Kaarina, Oiva, Tuula and Pekka]
- 9 They left after buying some items, including toys
- 15 Heavy rain and thunder
- 16 Photos taken at Sunila
- 22 Vesa home after spending time with relatives. Maija, Marjatta and Ilpo also arrived
- 23 Maija left. I bought materials for packing cases
- 24 Marjatta and Ilpo left
- 25 Started making the packing cases. Month was nice and warm

SEPTEMBER 1954

- 3 Packing cases ready
- 11 Sauna with Suoknuutti's at Lankila
- 12 Maija visiting again
- 13 Packing cases loaded
- 17 Cases to storage. Thunderstorms
- 20 Pyötsiä's visiting
- 22 To Helsinki to pick up Visas
- 23 "Innamo" departed for Glasgow with our gear
- 27 Passports stamped. Lydia came to do some sewing

OCTOBER 1954

- 2 Farewell party for Rautjoki's and Kärkkäinen's
- 4 Last day at work
- 5 Picked up wages. Farewelled by company and workmates
- 7 "Storm raged, Everything's gone"
- 8 Visited Elomaa's and Suokuutti's
- 9 Last sauna at Elomaa's

The diary of Toivo Nurkka, one of the 12 men to travel to New Zealand on the Captain Cook with his wife Aili and their five children, gives some insight into life in Finland prior to emigration⁴⁰. Toivo commenced his diary in 1947 while living in Sunila and working at the local mill. Significant births, marriages, baptisms, school starting dates, deaths/funerals and visits to graves to place flowers are noted, as are significant celebrations such as Christmas, New Year, Pentecost and Midsummer. The diary is punctuated with descriptions of the weather - mostly cold and raining, or frosty and snowing with temperatures falling as low as -20 Celsius, although the infrequent warm weather is also noted. The planting of the family garden in an allotment is documented in detail including purchasing of seeds, garden activity such as turning soil to prepare for planting, planting various crops, and the various yields of tomatoes, potatoes, carrots, beetroot and swedes. Sometimes, what was 'put in the pot' and when it was eaten is noted. An allotment was required because like many families, the Nurkka's lived in an apartment. There are many references to berry picking locations and yields, including bumper collections of blueberries (30kg), puolukka (lingonberries) (60kg), as well as wild mushrooms.

There are a number of visits to the doctor and dentist by the family members, mostly for minor illnesses or accidents resulting partly from the boys' various youthful adventures. School pupils are x-rayed in 1954, which appears to be a public health initiative as opposed to being specific to Toivo's children. Their life was very social with many visits to and from family and friends, and trips away to visit people, including the children having holidays with family and friends. There were lots of leisure activities such as watching horseracing, skiing, rowing and motorcycle races, celebrating midsummer with a bonfire and dancing, swimming and going to the beach, watching fireworks, attending airshows, exhibitions and festivals, trips away and holidays, going to the pictures, sledging, skiing, visits to various landmarks and attending sauna with family and friends.

Mill life is recorded, including timing of shuts, power failures and other operational events, changes of job, as well as the mill sending Toivo for x-rays and regular medical checkups. Notable family purchases are recorded such as the cost of sled repairs (600 marks), pram for the new baby (1,500 marks), ski boots for one of the boys (119 marks), materials to build pigsty (700 marks), piglet purchase (6,500 marks), radio repair (1,350 marks), sewing machine (27,980 marks), and bicycle for boys (11,000 marks). Toivo built a number of items for the home including a loom for Aili and storage chests, which were then decorated with painted flowers.

⁴⁰ I am very grateful to Toivo's son Osmo and daughter-in-law Aggie for generously sharing this diary with me and for giving me permission to use in my thesis.

Toivo documented the trip in his diary (excerpts).

OCTOBER 1954

- 10 To Helsinki, staying the night at Herttoniemi
- 11 Seutula Airport, flew via Kristiansand [Norway] to Glasgow [Scotland] Airport.
From there by bus to our ship "Captain Cook"
- 12 Ship cast off 11.30am and by evening it started to roll
- 13 Strong headwind
- 14 English lessons began
- 15 Skies cleared and weather warmed up
- 16 Big swells rocking the ship. Nobody seasick. Passed by Azores Island at 8.00am.
- 18 Wind from astern. Raining in the morning. Set watches to 4.5 hours behind Finnish-time
- 19 Wind changing to a headwind and getting rougher
- 21 Sea getting calmer and sun warming us up
- 22 Temperature rising, sweating easily
- 24 At 4.00pm islands coming into view. 7.00pm city lights in sight. 9.00pm tied up in Curacao to take on oil
- 25 Went ashore, bought mementos. At 5.00pm ship sailed
- 26 Very hot, no wind
- 27 5.00pm Arrived Colon, start of the Panama Canal. Went ashore
- 28 At 9.30am sailed into the canal. Plenty to see. Cleared the canal by 6.00pm.
- 29 Raining and cool
- 31 Crossed the Equator. Overcast

NOVEMBER 1954

- 1 Little more sunshine
- 3 Beauty and leg contests. Overcast
- 5 Sunny and warmer
- 9 Cool weather. Concert in the evening

Toivo documented the early months in Kawerau in his diary (excerpts).

NOVEMBER 1954

- 15 Arrived in Wellington at 5.50pm. Stayed at anchor over night
- 16 Lost a day [Tuesday]
- 17 Wednesday, still at anchor. Getting customs clearances etc
- 18 8.00am tied up at wharf. Left the ship at 2.50pm. Bus to railway station to catch the 4.40pm to Frankton. This journey took 13 hours.
- 19 Arrived in Frankton at 6.00am. Ate breakfast and continued by bus to Kawerau arriving there about 11.00am. This was Friday. Day was overcast. Staying in Tasman House.

- 20 Saturday. Keys to our house handed over. Lajunen's and others from Tokoroa arrived to welcome us to New Zealand. Warm day
- 21 Furniture selected for the house
- 22 Hire purchase agreement made
- 26 Schooling for "Jukola's" boys restarted
- 27 Spring cleaning the house. Testing fireplace etc
- 28 Nice warm day. Boat racing at Kawerau lake. Lajunen's came over
- 30 Laid lino in the house

DECEMBER 1954

- 1 Packing cases arrived 11.30am. No breakages. Bicycle assembled
- 4 Moved out of Tasman House into our house
- 5 Last meal at Tasman House
- 6 Schooling started after weeks rest
- 7 Planted flowers and tomatoes
- 10 More furniture arrived. Went shopping in Whakatane. Raining
- 11 Laid lino in laundry, bathroom and toilet. Raining. Nurmiaho's and Saikkonen's arrived.
- 14 English lessons for ladies started
- 15 Innoculation £1-15s-0p
- 20 First day at Tasman Mill, emptying saltcake from wagons
- 22 Children's Christmas party. Raining
- 23 Went to Tokoroa. Sauna felt good after such a long time
- 25 Came home and Lajunen's came to our place
- 26 Climbed Mt Edgecumbe. Warm day. Very pleasant end of year

Toivo's diary continues to document his family's life in Kawerau. In many respects, life settles into a pattern similar to that which he and his family had known in Finland. The diary continues to be punctuated with descriptions of the weather – now a balance of frosts, cold and rain with extended periods of warm weather. Notable family purchases are still recorded such as the purchase of a radio, electric heater (£3.12s.6p), spectacles (£5.10s.0p) and a Leonard refrigerator. The purchase of Toivo's first car is noted with some pride - a 1952 Humber, price £440, mileage 52,496. Toivo writes that he passed his driving test, got his license and went to work in his car. A few days later he had the "first trip to Whakatane in my car" and a couple of weeks after that he drove the family to visit Finnish friends in Tokoroa. Future car purchases by Toivo and his sons are noted, as well as maintenance details. Another source of pride is when a daughter is born to Toivo and Aili on 26th August 1958. Many of her various milestones are noted and Toivo constructs various items including a high chair for his new baby daughter, and then later a playhouse and chairs. In 1970 Toivo builds a loom for Aili, just like he had done in Finland many years before. Their life continues to be social with many visits to and from friends, as well as involvement in the activities of the Finnish Club and church life.

Ties with Tokoroa Finns, particularly Pauli and his family, continue throughout their lives. Earthquakes are mentioned. Mill life at Tasman is recorded, including his experiences in the causticising plant and then later bleach plant, pressure to increase production volumes and various bouts of strike action. Also included are some workplace accidents he experienced through contact with chlorine. Just as he did in Finland, the planting of the family garden is documented including what was planted in the garden as well as the planting of fruit and other trees like apples, pears and birch. In New Zealand, however, the garden was planted on the house section as opposed to an allotment. House and section experiences are also noted, such as building a fence and mowing the lawn which would have been somewhat of a novelty after apartment living. Maintenance and renovation activity over the years is described. While not as frequent or plentiful as in Finland, some blackberry picking is mentioned. Leisure activities continue such as going to the pictures, trips around New Zealand, trout fishing, swimming, going to the beach, holidays with other Finns, and skiing.

Significant events such as confirmations, christenings, weddings, hospitalizations, retirements, births and deaths/funerals are still noted, as well as events in Kawerau life such as town celebrations and bushfires, as well as farewell parties for Finns leaving New Zealand and parties for those Finns who subsequently returned, or Finns who newly migrate. Significant events that happen in Finland are also recorded such as deaths and other news received by letter from friends and family in the home country. Letters and parcels received from Finland are noted. Celebrations continue and are shared with other Finns such as Christmas, New Year, significant birthdays (such as 50th, and then in the New Zealand tradition a 21st), Mayday, Finnish Independence Day, and Midsummer. Like in Finland, there are some doctor visits for relatively minor complaints and Toivo and his family continue to keep good health aside from a heart condition that Toivo develops late in 1972 and one serious health condition experienced by one of his sons also in 1972. Both conditions impact their lives into the future.

The diary notes, with great sadness and tenderness, the death of Aili on 5th July 1973 as the result of an accident. Aili was farewelled by her husband, six children, two daughters-in-law, one son-in-law, seven grandchildren and members of the Finnish and Kawerau community, and remembered by relatives in Finland. It would be six months before Toivo would write in his diary again. Toivo retired from Tasman in January 1975 after 40 years of shift work. He continued to live a good life and died peacefully in his home on 4th November 1987. The final diary entries are written by his son, Osmo, noting the details of the funeral service at the Kawerau Lutheran Church, and his final resting place with Aili at the Kawerau Cemetery, just as Toivo had faithfully recorded for his beloved Aili.

Appendix Five – A Brief History of Finnish Migration to New Zealand

1769-70	Spöring sails into Poverty Bay on the Endeavour with Captain Cook
Early 1800s	A small and transient population of Finns arrive with the whalers and on merchant ships
1854	The first Finn is recorded as a permanent resident
1860s	A few dozen Finns arrive from Australia in search of gold
1871	Prior to the 1871 census it is estimated there were about 50 Finnish residents in NZ
1914 – 1918	<i>First World War</i>
1921	314 Finns in NZ according to census data, mostly aged between 16 and 30 years
1929 - 1930s	<i>The Great Depression</i>
1930s	Depression labour plants the largest manmade forest in the world, covering 160,000 hectares with pine trees.
1939 – 1945	<i>Second World War</i>
1941	A minor peak in Finnish immigration resulting from the seizure of New Zealand's first ever prize of war – the Finnish Ship s/s Pamir
1949	A NZ delegation visits Helsinki and attempts to get both Governments to support the migration of Finnish timber workers
Late 40s - early 50s	Finns are working to build and then work in various Mills in NZ
1950	Finland declines to pay passage for migrant Finnish timber workers in exchange for jobs and entry to NZ
1951	National Government enters into a joint venture with the Fletcher Group to form the Tasman Pulp and Paper Company Ltd (Tasman) to process the Kaiangaora pine trees
1953	Kinleth advertises in Finland for skilled recruits to the Mill in Tokoroa with the company arranging for passage and accommodation. This is supported by the NZ Government.
1953	Tasman begins construction of a pulp and paper mill in Kawerau including a pulp and paper plant, sawmill, wood preparation plant, and a paper finishing plant. Houses and public buildings in the town of Kawerau commence construction.
February 1954	First school opens in Kawerau
1954	Tasman advertises in Finland for skilled workers for the new Mill. From 200 applicants, 17 are selected - the first of the Kawerau Finns.
November 1954	The first of the Kawerau Finns (24 adults and 32 children in all) are met at the port of Wellington by a Tasman representative and travel by train and then bus to

	Kawerau. Inkeri arrives with her husband. Rauno, Katie, Aino and Einari arrive as children with their families.
December 1954	Five more families arrive. Niilo and his wife Helvi arrive with their children.
February 1955	The Kawerau Sauna Club was formed and the Sauna built
October 1955	Tasman's No.1 paper machine begins production
1958	789 houses had been completed in Kawerau as well as public buildings and the population was 3,500.
1958	Lutheran Sunday School established
1954-1959	Friends and family of Kawerau Finns make their own way to Kawerau. Sakari and Kaarina arrive with their children Hilja and Rachel
1960	Approximately 150 Finns in Kawerau, growing to 200 by the end of the 1960s
June 1961	Finnish Club formed
December 1962	Tasman's No.2 paper machine commences production
1962	Kawerau population reaches 5,000
1962-1963	Eleven Finnish men arrive to work on the No.2 paper machine, bringing their families with them. Mikko and Aila arrive with their children. Eino and Pentti arrive as children with their families.
July 1963	Decision taken to build a Lutheran Church in Kawerau and fundraising commences
October 1964	Kawerau Lutheran Church officially opened
Mid 1970s	New Zealand experiences an economic depression
March 1984	Finnish Club closes
1987	Approximately 50 Finns left in Kawerau
Mid 1990s	New Zealand's economy revives
Mid 1990s - present day	Migration of Finns continues to New Zealand in small numbers

Appendix Six – My Family Pulla Recipe

Let me tell you how to make pulla as my Mummu taught me. First you get a big pot. Put in 1 litre of milk and warm it slightly. Add in 100g of live yeast (but if can't get that, use around 5 tbsp of good dry yeast). Add 1tsp of salt, 1 ½ cups of sugar, 2 eggs and 2 tbsp of good quality cardamom. Stir it around with a wooden spoon a bit. Add 2 kgs of high quality flour. Mix and knead it in the pot until all the flour is well combined. Add 350g of softened butter (or margarine). Knead until elastic and glossy. Good pulla takes muscle power – knead until your hand hurts! Cover and let rise in a warm place for around 15 minutes or until when you poke your finger in the dough it bounces back. Fashion the dough however you like and fill what whatever you like (some suggestions pictured below). Let it rise again until it bounces back on your finger. Glaze with an egg/water mix and sprinkle with a mix of sugar and cinnamon or almonds. Back at 200 Celsius for 10 minutes for individual pullas, or 20 minutes for a plait or in a cake tin.

We make a variety of different styles of pulla but the mainstays for us are described below. For individual cinnamon pullas, roll dough out into a rectangle around ½ centimetre thick. Spread with softened butter or margarine, leaving a strip at the top free. Sprinkle cinnamon/sugar mixture onto the spread. Roll into a tube. Cut pieces as shown below, turn on their side and use the long side of your finger to press down into the middle to make the shape below. Or, you can just cut up however you want and cook.





Plait as the Finns do (below) which I can't possibly explain here! Or just make a normal plait with three tubes of dough as you would hair.



Adding marzipan and almonds and cooking in patty pans is a favourite.



Finally, cooking pulla in a cake tin works well with a variety of fillings, including jam. All types of pulla freeze well.



For special occasions, large pulla are often made, with the hole in the centre filled with other Finnish treats.



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