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The Career Trajectories of Immigrant Women in the Finnish Healthcare

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The purpose of this thesis was to explore the career trajectories of immigrant women in the healthcare sector in Finland. The objective was to investigate the “transitions” immigrant women encountered and to delve into experiences and the challenges they faced using the theoretical frameworks of Transitional Labour Markets, Self-efficacy, and Interpretative Phenomenological Analysis.

Semi-structured interviews were conducted with ten immigrant women working in the healthcare sector. A combination of convenience and snowball samplings was used. The key recruitment criterium was to be a first-generation immigrant working in the Finnish healthcare sector.

The results showed that the path of immigrant women into the healthcare sector is extremely long, and with many challenges. The educational system and employment in healthcare function well. However, at work, immigrants experience difficulties and decreased motivation due to challenges in integration into the workplace. These included language difficulties, discrimination, and mistrust from co-workers, supervisors, and patients. High self-efficacy helped the interviewed women to overcome these challenges and find their place in healthcare.

The results lead to the conclusion, that after a huge amount of effort put in at individual and institutional levels in training, not fully using the immigrants’ abilities could be considered a huge waste. Therefore, work aimed at changing attitudes towards care workers, as well as immigrants working in the system, should have a positive effect on the attractiveness of the segment for new and existing employees. By creating more diverse, inclusive, and equitable workplaces, healthcare in Finland could rise to an exemplary level.

Keywords	Immigrant woman, healthcare, labour market, career path, transition, self-efficacy

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1 Introduction

In today's rapidly changing, dynamic world, immigration represents the most prominent expression of globalisation (McAuliffe & Triandafyllidou 2021: 10). Approximately 8.5% (Statistics Finland 2022a) of the total population residing in Finland are people with foreign backgrounds, ergo forming a substantial and diverse minority community. With increasing immigration, labour market inclusion is becoming more pronounced.

The welfare system in the Nordics has an emphasis on work-based integration. It is believed that the prevention of social exclusion is possible through employment. As the labour market is an essential venue for freedom and equality, it has been selected to be the point of focus in the integration process. One can get more financially independent through work and earn a higher place in society.

Starting from 2006 until today, a significant theme in the government's immigration policy has been to bring workers from outside to Finland in industries where labour is scarce. (Simola 2010.) Immigrants are needed to address labour shortages and to reduce dependence ratios due to population ageing. (Prime Minister's Office 2019: 16.) The ratio between the working-age population and pensioners will continue to decrease. Typically, this results in higher taxation and other economic pressures on society. In Finland, the pension reform of 2017 started to slowly increase the retirement age. (Finnish Centre for Pensions: 4.) This, together with the immigrant population entering the labour market, was planned to even the scale. However, lower-than-expected birth rates and lower-than-anticipated immigration have endangered the sustainability of the current pension system (Parviala 2021). Ageing population also puts more pressure on the healthcare system.

In Finland, the total unemployment rate in 2022 was fluctuating between 6% and 8%, showing a declining trend after the COVID-19 pandemic. At the same time, the percentage of unemployed immigrants was around 27.5%. While employment rates between immigrant men and Finnish men are not significantly different, the case is not the same with women, where around 56% of immigrant women are employed, while for Finnish women the number has been 73%. (Statistics Finland 2022b.) One reason for

this dissimilarity is related to cultural differences and the traditional roles within the family. (OECD 2020: 7.)

Many professionals from immigrant backgrounds work in the social and health sectors, and due to the labour shortage, they will be more required in the future. However, finding employment in the social and healthcare sectors is challenging. Along with the absence of the Finnish language, another factor is not recognising the previous studies of immigrant employees. One factor could be the way Finns feel towards immigrants. Finland was found to be one of the most discriminating nations in Europe, according to a survey done by the EU Agency for Fundamental Rights (Repo 2017). Five hundred first- or second-generation immigrants from the capital area were surveyed for the study. Discrimination is a problem, particularly when applying for jobs and using state-provided services.

Women have traditionally been the majority in the healthcare sector's workforce. In September 2022, 86.6% of employees in the Human health and social work sector were females. (Statistics Finland 2022c.) The shortage of workforce in the healthcare sector has been tried to tackle by various programs that would educate the foreign workforce for the Finnish healthcare system. Recruiting nurses from the Philippines and degree programmes in nursing aimed at immigrants are examples of these. However, research by Vartiainen (2019: 72.) shows that immigrant nurses have been underpaid and discriminated at the workplace. The full scale of their professional skills has not been utilised, and their career paths are limited.

This thesis is an attempt to contribute to the knowledge of the career trajectories and experiences of immigrant women in the Finnish healthcare sector. Even though there is research showing the difficulties of immigrants in the healthcare sector, like language skills, onboarding, discrimination, and others, there is no knowledge of how the career paths of immigrant women develop in the healthcare sector. (Tehy 2021.) The endeavour of the thesis is to delve into the barriers and challenges immigrant women have had when finding their way into and within the Finnish healthcare system. The method of investigation is in-depth interviews.

1.1 Objectives

The purpose of this thesis is to explore the career trajectories of immigrant women in the healthcare sector. Gunther Schmid's (1995) Transitional Labour Market theory (TLM) will

be introduced, and the "transitions" experienced by immigrant women will be investigated. As the labour market has evolved since the theory was developed, a wider scope of "states" (from the traditional unemployment, employment, and inactivity) will be considered.

To delve into experiences and the challenges the women faced during "transitions", the Social Cognitive Theory by Albert Bandura (1986) will be applied. Self-efficacy, being a key concept within the Social Cognitive Theory, will be used as a tool to decode the potential challenges as hurdles or barriers.

The research questions are:

I. What career paths have immigrant women in the healthcare sector taken?

II. What have been the experiences of changing "states" (transitions) in these career paths?

1.2 Definitions

The following chapter introduces the key terms used throughout this thesis. The interpretation of these terms is also clarified.

1.2.1 Immigrant

The term immigrant is defined as a person who comes to a country to take up permanent residence (Merriam-Webster Dictionary). This indicates that an immigrant was born outside of the destination country. However, the definition in real life is broader.

According to the classification of Statistics Finland, which is based on one's origins, all persons with their parents, or the only known parent, born outside of Finland are considered persons with a foreign background (2022d). By this definition, a child born to immigrant parents without a Finnish passport is also viewed as someone with a foreign background. Thus, there is no clear separation between first- and second-generation migrants. "Person with foreign background" is used interchangeably with the term immigrant in this study. However, asylum seekers are not considered immigrants in the Statistics Finland data since they do not have residence permits. (Helminen & Keski-Petäjä 2016.)

1.2.2 Healthcare sector

In this thesis, the healthcare sector is defined as the industry that provides medical goods and services to diagnose, prevent, and treat illnesses and diseases, as well as to promote overall health and well-being. It includes a wide range of organisations, such as hospitals, clinics, physician practices, assisted living facilities, diagnostic laboratories, medical device and pharmaceutical manufacturers. The healthcare sector is an essential part of the economy in Finland and plays a vital role in improving the health of individuals and populations. In the healthcare sector, there are various regulations and policies to ensure the safety and quality of care provided to patients.

1.2.3 Healthcare worker

Healthcare workers can be defined as persons who work in the healthcare sector and provide care, assistance or treatment services to individuals who require assistance due to physical or mental disabilities, illnesses, or old age. They can work in multiple settings, including private homes.

1.2.4 Labour market

In the classic definition, the labour market is the virtual venue where employees and employers connect. The employers try to find the best candidates, and the employees try to maximise their satisfaction. In a free labour market, the level of wages is defined by supply and demand. However, in the practical world, trade unions and governments influence salaries. (Economics Online 2020.) As this thesis explores the personal experiences of immigrant women in the Finnish healthcare sector, a broader analysis of the labour market itself is omitted.

2 Background

This chapter discusses healthcare as a labour market from different perspectives. The Finnish healthcare system, an overview of immigration in Finland and the position of immigrant women working in the Finnish healthcare sector are introduced.

2.1 Healthcare Labour Immigration and Gender Perspective

Immigration plays an important role in the healthcare labour force in many countries, with immigrants filling critical gaps in the healthcare workforce. Gender also plays a significant role in healthcare labour immigration, as women have traditionally been linked with care work (Cleland Silva 2018: xv). They are often overrepresented in lower-skilled healthcare occupations, such as nursing aides, home health aides, and personal care aides. These jobs are often characterised by low pay, lack of benefits, and limited opportunities for advancement, leading to concerns about labour exploitation and inequality. A study by the Migration Policy Institute found that in 2018 foreign-born immigrants made up nearly 18% of employees working in healthcare occupations in the United States (Batalova 2020). Women accounted for 75% of these immigrants.

Traditionally, immigration in the healthcare sector has been from poorer countries to richer countries, typical destinations being the United States, Australia, Germany, France, the United Kingdom and New Zealand. Language and “colonialism” relations can be detected in immigration habits. (Buchan, Parkin & Sochalski 2003: 58.) “Chains” of migration can be recognised, where a country lower in the chain is feeding human capital to the country higher in the chain. (Yeates 2009.) The lowest in the chain is thus drained out of resources.

However, the languages in Nordic countries are not spoken elsewhere in the world. Because of this, the immigration trends within the healthcare sector have been following a different formula. Immigration has been occurring mostly within the Nordic countries and has been dependent on the employment opportunities and economic situation in a specific Nordic country. Since the early 2000s, the interest in work-based immigration in Finland has been increasing due to the lack of a workforce. There have been attempts to bring nurses to Finland with the intent of filling the gap of skilled healthcare professionals. A qualitative study by Cleland Silva (2018) characterises the experiences of Filipino nurses as feeling excluded, de-scaled and discriminated. In the beginning, the key challenge was mastering the Finnish language. However, later having fluent language skills, the nurses still felt ignored with limited opportunities for career advancement.

Traditionally, care work has been performed by women, both in paid and unpaid contexts, that is derived from the gender norms and expectations that position women

as the primary caregivers in families and communities. Women are associated with being nurturing, empathetic, and self-sacrificing, qualities deemed essential for care work, often seen as "women's work" and less important or valuable than other forms of work.

2.2 Immigration and Finland

The population of Finland has been very homogeneous due to its isolation geographically and because of the country's rigid immigration policy. (Leitzinger 2008.) Until the early 1980s, the trend was to emigrate from Finland to find better job opportunities abroad due to the oversupply of the workforce. (Heikkilä & Peltonen 2002: 2.) The "baby boom" after the second world war (WWII) first overloaded the healthcare and education systems and, later, the labour market. In addition, women started actively participating in working life. (The Finnish League for Human Rights 2002: 7.) The most popular countries to emigrate to apart from the European countries were the United States of America and Australia (Rapo 2011).

Until the 1970s, Finland was not a very attractive destination for immigrants. The ones coming were mostly married to a Finn, had a short-term work assignment or were students (Nshom, Khalimzoda, Sadaf & Shaymardanov 2022: 47). However, as the economic situation between Sweden and Finland equalised, many Finns returned home, contributing to approximately 85% of all immigrants entering Finland (Korkiasaari & Söderling 2003: 7).

In the 1990s situation changed due to instabilities in the world. The fall of the USSR and the wars in Yugoslavia, Afghanistan, and Somalia contributed to the increase in the number of immigrants. This period had the peak numbers in unemployment, around 20% of the workforce. Finland became a part of the EU in 1995 and joined the Schengen area in 2001. This made freedom of movement within Europe increasingly easier.

In the early 2000s, the public discussion on work-related immigration to Finland emerged. In 2006, the government of Matti Vanhanen set work-related immigration as their primary goal in the immigration policy (Simola 2010: 79). From then on, emphasis on work-related immigration has stayed in governments' immigration programs. For example, the Strategic Programme of Prime Minister Juha Sipilä's Government states the following on immigration policy:

> The Government will promote work-related migration that enhances employment in Finland, boosts public finances, improves the dependency ratio and contributes to the internationalisation of the economy. The whole of Europe is ageing and will have to deal with the resulting problem of public deficits. Immigrants enhance our innovation capacity and increase our know-how by bringing their cultural strengths to Finnish society. More and more young people are leaving Finland to study abroad, and we will have to compete for our own youth as well. (Prime Minister's Office 2015: 40.)

In recent years, the ageing population and declining birth rates have been a burning topic as the baby boomers born in the decade after WWII are now retired, and the birth rate in Finland has gone down. The solution proposed for upkeeping the social system is through the immigration of the workforce and by increasing the retirement age. This has strongly been reinforced in the Programme of Prime Minister Sanna Marin's Government (Prime Minister's Office 2019), resulting in many initiatives to ease and quicken the process of getting a residence permit to Finland based on work-related matters. As an example, the processing times of the employed applicants improved from 143 days to 75 days between 2020 and 2021 (Finnish Immigration Service 2022a).

Work-related immigration has steadily grown both in amount and the share of the total since 2015, when there were 6321 (27.1% of all) decisions for the first residence permit to Finland on the grounds of work. In 2021 the amount was 13775 (43.06% of all), and work was the most common reason for immigrating to Finland. (Finnish Immigration Service 2022b.)

2.3 The healthcare sector in Finland

The healthcare sector or healthcare industry consists of the parties that provide products and services to patients. In some cases, instances that provide regulation, training, and education for the healthcare sector are considered part of the healthcare sector. (FutureLearn 2020.)

The healthcare system in Finland is based on public and private healthcare providers. Everyone has a right to public healthcare, but one can choose private healthcare if desired. (Ministry of Social Affairs and Health.)

Municipalities are responsible for providing and funding public healthcare. They can produce the services independently, together with other municipalities, or by procuring them from private healthcare providers. The municipal health centres carry out the

primary health services. Hospital districts are formed in collaboration with municipalities, and these district hospitals provide specialised healthcare. There are five catchment areas consisting of joint municipality regions that provide the most specialised healthcare services. University Hospitals of Helsinki, Turku, Tampere, Oulu, and Kuopio are the basis of these catchment areas. (EU-healthcare.fi.)

In Finland, approximately a fourth of all healthcare services are administered by private providers. They either sell services to the public sector or clients directly. The private sector is partially funded by the government. Finland's social security organisation, KELA, reimburses part of the medical expenses of patients. (EU-healthcare.fi.)

In this thesis, the interest is in the career possibilities and experiences for immigrant women, regardless of the sector being private or public providers of healthcare.

2.4 Healthcare sector as a labour market

The total costs of the healthcare system in Finland are approximately 15 billion euros per year. Three-quarters of this are provided by public funding. (Terveystalo 2022.) The total costs include both social and health services. Around 16.6 % of the total workforce in Finland is employed in the social and health sector (OECD 2021).

According to a report by the Ministry of Economic Affairs and Employment of Finland, in 2019, there were 407 427 people employed in the social and healthcare sector (Tevameri 2022: 15). Social and healthcare is the biggest sector in Finland in the number of employees. The second largest is the industrial sector, with 297 502 (in 2019). The three largest professional groups within social and healthcare were practical nurses, registered nurses, and social instructors.

The division between the public and private sectors is more complicated since, as an example, a physician may work for both a public healthcare centre and a private healthcare service provider. According to the Ministry of Economic Affairs and Employment in Finland, 31.4% of social and healthcare professionals worked in the private sector in 2019 (Tevameri 2022: 23). The number is higher than the statistics Finland provided numbers due to differences in the classification of professions within the social and healthcare sector. The most common social and healthcare sector professions within the private sector are Physiotherapists, Dental Technicians, and

ambulance staff. The new positions in the social and healthcare sector have been around 60% temporary and 40% permanent. (Räisänen & Ylikännö 2021: 9.)

Overall, the social and healthcare sector could be considered as not attractive as an employer. It has a chronic lack of resources. In 2020, more than 4500 permanent positions were left unfilled. The number was around 2000 lower than the year before. (Tevameri 2022: 41.) For temporary positions, the numbers are a lot worse. Over 30 000 temporary positions were left unfilled. In the sector, temporary recruitments last less than in other sectors. As an example, from new recruitments for a temporary position of a week or less, the social and healthcare sector took around 90% of all recruitments (Räisänen & Ylikännö 2021: 11).

Job satisfaction plays a key role when upkeeping long careers. Especially, nurses in Finland have a long history of dissatisfaction on the job. As an example, a study conducted in 2008 shows that job dissatisfaction is directly related to the increased motivation to look for other professions. Additionally, one of the main reasons to leave the profession of nursing amongst under 30-year-olds was low wages. (Flinkman, Laine, Leino-Kilpi, Hasselhorn & Salanterä 2008: 729.)

The number of applicants in nursing programs has decreased. Furthermore, the number of education places in nursing programs has decreased from around 7200 to around 5000 in the last eight years (Lehtokari & Manninen 2022).

The COVID-19 pandemic has further decreased the workforce in the social and healthcare sector. As the pandemic hit Finland, the understaffed hospitals and medical centres had to make the employees work overtime. This resulted in nurses being exhausted and actively considering changing their profession. One of the findings in a survey conducted by Aula Research in September 2020 was that 48% of employees in the public healthcare sector were actively thinking about a career change (Tehy 2020), and 88% had at least thought about it. 64% of the employees would select a different sector to work for if they were to begin their studies now.

As the population is ageing and birthrates are low, there is a demand for a workforce in the healthcare sector. It has been projected that in elderly care alone, roughly 30 000 new positions will have to be filled by 2030.

The digitalisation of the world will also affect the healthcare sector. The border between technology and health services will become more obscure. How will automation and artificial intelligence impact the need of healthcare professionals? As efficiency is one area that constant efforts are being put into in other industries, this will certainly affect the social and healthcare sector, too.

2.5 Immigrant women in the healthcare sector

In 2012, there were 16 204 persons with foreign backgrounds working in the social and healthcare sector in Finland (Ailasmaa 2015: 46). This corresponds to a bit over 4% of the total within the sector. The highest concentration of persons with foreign backgrounds was amongst physicians (8.4%). Unfortunately, more recent statistics are unavailable due to the discontinuation of the data recording (Statistics Finland). Thus, there is no accurate, current data on immigrant women, either.

It is challenging for workers with an immigrant background to enter the healthcare labour market. A study conducted by Tehy (2021), the largest healthcare workers' union in Finland, concluded that 95% of the survey respondents thought that limited language skills were the main challenge in the recruitment process of immigrants. In healthcare, mastering the language is exceptionally important since it concerns the safety of the patient. Onboarding was the second most popular challenge, according to the respondents. The conclusion made by the study was that employers have a great responsibility to organise proper onboarding and language training.

Recognition of previous studies in healthcare is also a long and complicated process. According to Tehy (2021) research, more than 40% of educated immigrant nurses experienced difficulties with degree acceptance in Finland. Typically, degrees received in countries outside of the EU are not fully recognised, and one must get retrained by the Finnish education system.

According to several studies, it was discovered that it is problematic for immigrants to develop and grow their careers corresponding to their education and experience; hence immigrants' knowledge and skills are not fully utilised. Also, it was found that often immigrants in healthcare are overqualified for the job they occupy. For example, registered nurses can work as practical nurses (Larja & Luukko 2018: 40).

Another research on immigrant women, which studied Filipino nurses' motivations, revealed that among other main motives for coming to Finland, like earning money and sending money home, was advancing careers and opportunities for further education. However, in many cases, the ambitions and motivations were not fulfilled during work in Finland. (Vartiainen, Pitkänen, Maruja, Raunio & Koskela 2016: 44.)

Maire Antikainen's (2010) dissertation "On the journey to becoming a Finn and a care professional" looked at how immigrants might establish their sense of belonging to Finnishness and what kind of positions are possible for an immigrant woman. Russian and Estonian background women were researched in the study. The study found that immigrant workers and students needed to construct themselves in accordance with Western cultural standards to be accepted by society. An immigrant root was viewed as an item that had been modified to match the Finnish working environment. The study also demonstrated that, despite immigrant women's education in Finnish culture, they were only able to achieve certain levels of positions.

3 Theoretical framework

The Transitional Labour Market theory (TLM) theory looks at the human career path with all its shades. The goal in life is not to purely get from unemployment to full employment but to have a sustainable and dynamic career with multiple transitions between working life, family life, and education. One may change their occupation, country, family status etc., in the middle of their professional career. The TLM model is an individual approach, where the periods of unemployment are seen as a positive "transition" and as means of preparation for the next step in the career.

Additionally, the social cognitive theory and especially self-efficacy will be explained. These theories will be used as a basis for the result interpretations.

3.1 Transitional labour market theory

In Europe, during the 1980s and the 1990s, there was a great deal of chronic unemployment. Günther Schmid (1998) and Peter Auer developed the Transitional Labour Market (TLM) theory as a complementary element for a reform proposal framework in solving the employment crisis. The TLM considers both working time and states "between jobs" being useful activities when preparing for the next transitions in

life. Unemployment should not be considered as a negative state but an opportunity to develop oneself and create new social networks for the future.

The fundamental word in the TLM theory is the transition, which means a link or a gangway (übergänge in German). Originally, the transition was defined as moving from a reference state to full-time employment. (Gazier & Gautié 2009.) In a wider interpretation of the theory, there are a plethora of transitions in and out of full employment. Some of the examples would be transitioning to and from parental or study leave. In this view, any change from a relatively stable state to another is considered a transition. There are five types of transitions, according to Schmid (2001: 235):

- Transitioning from education to employment
- Transitioning from partial or self-employment to full employment
- Transitioning from non-salaried social or private work and market work with wages
- Transitioning from unemployment to employment
- Transitioning to retirement

The core of TLM is reaching full employment but in a “sustainable” way, including non-salary work like parental leave, study leave and voluntary work. One’s career should be considered a process of constant learning. There are four management principles in TLM:

Empowerment indicates that individuals have more opportunities to make meaningful choices in their career paths, and policymakers should provide these prospects. **Solidarity** recognises the interconnectedness of numerous socioeconomic groups in uneven labour market situations, as well as the need for a coordinated effort aimed at the disadvantaged. **Co-financing,** as well as **management by objectives,** seeks to create from grassroots to top-management initiatives, primarily at the local level, and to ensure the active engagement of all stakeholders.

3.1.1 Full employment

Full employment has traditionally been considered as working for 8 hours a day, 5 days a week, 46 to 50 weeks annually for around 40 to 50 years (Schmid 1998: 4). It is not

possible to reach 0% unemployment e.g., due to the movement of people and unpredictable economic shifts. When employees quit their job due to relocation or to trying to find better jobs, the phenomenon is called frictional unemployment. Changes in government policies or other changes in market needs are called structural unemployment.

According to Petri Syvänen, advisor at the Ministry of Labor and Economy, Finland has reached full employment when the unemployment rate is three to five per cent (Karjalainen 2017). There will always be incompatibilities between market needs and employee skillsets. TLM tries to offer an alternate approach to the traditional goal of full employment. Full employment should be approached with more "practical expectations". It should be considered more flexible, and more attention should be paid to the equality of the sexes. (Gazier & Gautié, 2009.)

3.1.2 Gender equality in TLM

According to OECD (2022: 1), there is less likelihood for women to be promoted. The reason for this is that women work more probably part-time. It is more probable for men to change a company and thus get pay raises. It is also suggested that women change jobs because of family reasons rather than to advance their careers (OECD 2022: 1).

Four major conditions should be realised to have an equal TLM. (Schmid 2001: 238.)

- **Empowerment** – This refers to infrastructure being in place to enable entering the labour market and not losing employment during transitions. An example is a working childcare system.

- **Sustainable employment and income** – This refers to having a chance to earn while doing unpaid work. An example is taking care of a small child at home.

- **Flexible coordination** – This refers to employers and employees having an agreement on pliant maternal and paternal leaves.

- **Co-operation** – This refers to allowing both parents to be on leave at the same time rather than having the leaves sequentially.

In Finland, these conditions are mostly met. The most recent change in childcare legislation is the family leave reform, which came into effect on the 1st of August, 2022 (Sosiaali- ja Terveysministeriö 2022). The reform enables both parents to have the right to take a leave to take care of the child. The total leave days have been increased. Additionally, parents can be on parallel leave for up to 18 working days (Lexia 2022).

According to the Kela report on family leaves, in 2021 only 11.1% of all parental leave days were taken by men (Pösö 2021: 7). The defence minister of Finland, Antti Kaikkonen, is planning to take parental leave from January 2023 (Suomenmaa 2022), and there are plans to go for a substitute during his absence. These arrangements have raised some discussion among the opposition politicians. Thus it is not yet a norm in Finnish society for a father to take parental leave. To reach a gender-equal labour market, men need to adjust their career behaviours to match the centuries-old patterns of women.

3.1.3 Transitions of immigrants

Transitioning from one's homeland into a new country creates additional challenges compared to transitioning within the country's labour market. Language and cultural differences come into play. One's support network will no longer be as available. Perhaps, this is one of the most difficult transitions in life since old roots have to be left behind and new roots have to be grown. It is essential to understand these difficulties in relaunching one's life as immigration is increasingly visible in everyday life in Finland. The women in this study have all gone through this transition and have successfully penetrated the Finnish healthcare labour market.

A study by Krutova, Lipiäinen and Koistinen (2016) focused on a longitudinal analysis of the integration of immigrants in Finland. They identified long-term patterns of labour market integration, categorised the typology of transitions and classified the reasons for transitions, such as age, gender, education, etc. The conclusions of this study were that education gained either in one's homeland or in Finland does not guarantee employment. Furthermore, a successful start in the labour market does not secure sustainable employment in the long term. There are multiple transitions an immigrant has to pass through. In general, differences in employment rates between immigrants and natives gradually vanish in around ten years of living in Finland.

For highly educated immigrant women, it takes a long time to enter the local labour market as the studies in their homeland are not recognised in the new country. For example, Germany is struggling with the decline of its productive population. A paper by Ulrike Scheffer suggests that the government should put more effort into second-generation immigrants and educate them in the German system thus getting them integrated fully into society (Scheffer 2019: 3).

3.1.4 Limitations in TLM

The TLM theory has been criticised for promoting changing one's status from employment to government-subsidized statuses, like studying or parental leave. This could be misunderstood as not being loyal to organisations and too costly for governments (Gazier & Gautié 2009).

To take TLM theory into use by governments requires funding. In this sense, the theory is limited socioeconomically to wealthy countries. Thus, it is not applicable to non-European contexts. (Atkinson 2010.) The infrastructure of third-world countries may not be ready to take the model into operation.

Another criticism voiced by Arne L. Kalleberg (2009) is that TLM does not provide a comprehensive framework for analysing transitions between different forms of non-standard employment. An example of this would be today's "gig-work" economy.

TLM may not take into account the speed of technology development and how it is transforming the labour market. This unprecedented pace of technological revolution leads to uncertainty and instability for workers. This criticism has been raised in the Journal of Technological Forecasting and Social Change (Frey & Osborne 2017).

3.2 Social Cognitive Theory

The Social Learning Theory (SLT), created by psychologist Albert Bandura in the 1950s and 1960s, is the ancestor of Social Cognitive Theory (SCT). Social Learning Theory proposes that people learn through observing others and the consequences of their actions (Bandura 1969).

SCT provides a comprehensive context for understanding the complex relationship between cognitive processes, behaviour, and environment in defining an individual's social experiences and outcomes.

The emergence of the Cognitive Revolution in the 1960s and 1970s saw a shift away from behaviourist approaches to psychology and towards an increased focus on the role of cognitive processes in shaping behaviour. Bandura integrated this new focus on cognition into his theory, and Social Learning Theory evolved into Social Cognitive Theory.

SCT is a theoretical perspective in social psychology that highlights the role of cognitive processes, including perception, interpretation, and attribution, in shaping one’s social behaviour. It suggests that people's thoughts, beliefs, and attitudes interact with their environment to influence their behaviour. SCT also underlines the importance of self-referential thought or the ways in which people think about themselves and their experiences, in shaping their social behaviour.

Some of the key concepts in SCT are:

- Observational Learning: According to SCT, individuals gain knowledge by observing others and the outcomes of their actions. People can acquire new behaviours and attitudes by observing others, and they can use this information to guide their own behaviour in similar situations.

- Attention and Encoding: According to Social Cognitive Theory, people can only process information that they attend to and encode. The way in which information is attended to and encoded influences how it is later used to guide behaviour.

- Mental Representations: Based on experiences and observations, people create mental images of the world. These mental representations, including beliefs, attitudes, and knowledge, influence how individuals perceive and interpret new information.

- Self-referential Thought: SCT suggests that people engage in self-referential thought, or thinking about themselves and their experiences. This self-referential

thought influences how people perceive and interpret information and how they behave in social situations.

- Self-efficacy: Self-efficacy is a crucial concept in SCT, and it relates to a person's confidence in their capacity to do a certain job or achieve a specific goal. High levels of self-efficacy are associated with higher motivation and persistence, whereas low levels are associated with decreased motivation and persistence.

- Reciprocal Determinism: SCT proposes that the relationship between people's internal cognitive processes, behaviour, and the environment is reciprocal (Bandura 1978). These factors can influence others, leading to a dynamic interaction that shapes a person's social experiences and outcomes.

Social Cognitive Theory has been applied to a diverse range of topics in recent decades, including health behaviour, organisational behaviour, and education. This has resulted in the theory's continuous evolution and refinement, as well as new insights into how cognitive processes and behaviour interact to shape social experiences and outcomes.

3.2.1 Self-efficacy

Throughout the 1970s and 1980s, Bandura elaborated on the notion of self-efficacy, which touches on one’s faith in their capacity to effectively carry out a particular task or meet a specific objective (Bandura 1977). Self-efficacy beliefs are crucial in dictating a person's behaviour and results. The concept of self-efficacy became the fundament of Social Cognitive Theory and was incorporated into the overall framework of the theory. Whereas those with low self-efficacy may shun difficult jobs and give up in the face of adversity, individuals with high self-efficacy are more inclined to embark on challenging tasks and persevere in the face of difficulties.

According to Bandura (1977), high self-efficacy beliefs are associated with a number of positive outcomes, including increased motivation, greater effort, persistence, and resilience in the face of challenges or setbacks. They view obstacles as challenges that can be overcome with effort and skill. Individuals with high self-efficacy are also more likely to set ambitious goals and put energy into achieving them, take risks, and pursue new opportunities.

On the other hand, low self-efficacy beliefs are associated with decreased motivation, feelings of helplessness, reduced effort, and a greater likelihood of giving up in the face of challenges. Individuals with low self-efficacy are also more likely to experience anxiety and stress when faced with difficult tasks. They may view failures as evidence of their lack of ability rather than as opportunities for growth and learning.

Self-efficacy can be developed and strengthened through various means. (Bandura 1977.) There are many conventions in naming these attributes, but the content is generally the same:

- **Mastery experiences** are direct experiences an individual has with a task or goal, such as successfully completing a challenging assignment or achieving a personal best in a sport. When individuals experience success, their self-efficacy beliefs are strengthened, and they are more likely to tackle similar challenges in the future.

- **Social modelling** involves observing others who are similar to oneself. When individuals see that people like themselves can accomplish a task or master a domain, they are more likely to believe they can do it too.

- **Verbal persuasion** involves receiving encouragement and positive feedback from others. When others express confidence in an individual's ability, that person is more likely to believe in their own ability.

- **Emotional and physiological feedback** refers to using biofeedback to monitor and regulate physical responses such as anxiety, stress, heart rate or muscle tension. Positive emotions can increase the feeling of self-efficacy.

- **Past experiences** can shape self-efficacy beliefs, even if those experiences were not successful. If an individual has a history of struggling with a particular task, for example, they may be more likely to doubt their ability to perform that task in the future.

- **Cultural beliefs and norms** can also influence self-efficacy beliefs. For example, individuals from cultures that value interdependence and group harmony may

place less emphasis on individual self-efficacy beliefs than those from more individualistic cultures.

Numerous studies indicate the importance of self-efficacy in various domains, including education (Pajares & Krantzler 1995), healthcare (Luszczynska, Benight & Cieslak 2009), and sports (Feltz, Short & Sullivan 2008). For example, a study by Pajares and Krantzler (1995: 432) found that self-efficacy was a significant predictor of academic achievement among high school students.

It is essential to differentiate between self-efficacy and other terms, like self-esteem, locus of control, and outcome expectations. They all are important constructs in the field of psychology, but they differ in their definition and focus:

As earlier explained, self-efficacy is faith in one's ability to plan and carry out the actions required for a certain goal and relates to an individual's confidence in their ability to accomplish this goal (Bandura 1977).

Self-esteem is an overall subjective evaluation of one's worth as a person. It is a more general construct than self-efficacy and reflects a person's overall feelings of self-acceptance, self-respect, and self-love. (Baumeister, Campbell & Krueger 2003: 1.)

The locus of control refers to how much people believe they influence the occurrences in their lives (Rotter 1966). The term locus of control can refer to a wide range of contexts. Those with an internal locus of control feel they have control over events in their lives, whereas those with an external locus of control believe that other circumstances, such as luck or the acts of others, have a bigger influence on their results.

Outcome expectancies are related to beliefs about the likelihood of outcomes resulting from certain behaviours. (Deutsch & Strack 2005: 53.) Outcome expectancies are based on past experiences, social learning, and other sources of information and can influence an individual's motivation and behaviour.

Typically, the self-efficacy concept is utilised in quantitative studies. Yet, Bandura believes self-efficacy needs not to be quantified and must be linked to a specific activity. (Bandura 2006: 307.) Despite the fact that the idea of self-efficacy is frequently encountered in quantitative research, a few qualitative studies on self-efficacy has been conducted (Glackin & Hohenstein 2018: 271). The notion of self-efficacy is applied

qualitatively in this study to capture immigrant women's views on the hurdles they have faced in Finnish healthcare.

Assessing self-efficacy qualitatively implies that participants will not be required to complete questionnaires with measurement scales. No quantitative data will be available. Rather, the conversation with women immigrants will be conducted in such a way that the interviewer will develop, formulate and ask questions around the insights on the challenges, opportunities and motivation that are strongly linked to self-efficacy. Thus, all attributes related to high and low self-efficacy will be explored.

3.3 Conclusion

The connection between life transitions and self-efficacy is that life transitions often require individuals to develop new skills or adapt to new situations, impacting their sense of self-efficacy. For example, if someone is starting a new job, they may feel uncertain about their ability to perform the required tasks. However, if they have a strong sense of self-efficacy, they may be more confident in their ability to learn and adapt to their new role.

Additionally, life transitions can be challenging and test an individual's resilience and coping skills. Those with a strong sense of self-efficacy are more likely to view challenges as opportunities for growth and are more likely to persist in the face of adversity. They may be more likely to seek out resources and support to help them navigate the transition and overcome any obstacles they encounter.

Women may experience life transitions such as relocating to a new country, starting a family, caring for children or ageing parents, or taking time off from work for other personal reasons. These transitions can impact their career trajectory and their sense of self-efficacy. Every transition is followed by a reaction and, eventually, an outcome. What kind of actions will be taken in facing the changes? How will the difficulties be tackled? In what kind of mindset will immigrant women be? 'The glass is half empty', or 'the glass is half full'? High and low self-efficacy plays a significant role in addressing these questions.

In summary, life transitions and self-efficacy are connected because life transitions can impact an individual's sense of self-efficacy and ability to adapt to new situations. In

contrast, a strong sense of self-efficacy can help individuals navigate life transitions with greater confidence and resilience. Understanding the role of life transitions and self-efficacy in immigrant women's career paths in healthcare may help to create more insights and understanding to help immigrant women achieve their career goals.

4 Research Methodology

This chapter describes the process of how the study was conducted. It portrays each phase of the study in detail and introduces concepts related to qualitative data analysis and phenomenology. The method of selecting the sample and a brief description of the participants and data analysis is introduced. Lastly, the ethical and quality considerations are discussed.

4.1 The Process of Research

This research was conducted using Marshall and Rossman's qualitative research process. The process has 6 phases: (i) identifying the research question, (ii) conducting a literature review, (iii) designing the study, (iv) collecting data, (v) analysing data, and (vi) writing the report. (Marshall & Rossman 2016.)

First, the central research question was identified. The healthcare sector is a challenging environment to work in since healthcare professionals are responsible for the lives of their patients. Career trajectories in healthcare are not straightforward, especially for immigrants. However, with growing immigration, an ageing population, and a shortage of healthcare professionals in Finland, the topic of immigrants working in healthcare is becoming more important. As Tricia Cleland Silva explains in her book, immigrant healthcare workers can be reduced to mere "human resources", but they are complex individuals with their own goals, motivations, and challenges, resisting various constraints and challenges, including discrimination, language barriers, and cultural differences. (Cleland Silva 2018: 2.)

The background chapter in this thesis reviews existing literature related to the research question. This helped to identify gaps in the literature and to develop the study design. The theoretical framework presented the TLM and self-efficacy concepts to examine the career trajectories of immigrant women and the experiences they encountered. TLM concept was chosen to learn all the transitions the women have gone through in

healthcare, and the self-efficacy concept was utilised to understand what helped or prevented them from achieving a certain goal.

The design phase, including sample selection, data collection methods, and the techniques used for data analysis, are explained in detail in chapters 4.3, 4.4, and 4.5. It was quite natural to select semi-structured interviews to learn about the career trajectories, experiences, and feelings of the participants. The development of the questions was an important part of ensuring that the needed data could be collected.

The data was collected by conducting face-to-face interviews. In addition to the verbal responses, the emotional and physiological reactions, and body language of the participants, helped to get a full understanding of their stories. Data analysis is presented in chapter 4.5. Finally, the result of the reporting phase in the process is this thesis. The findings and conclusions of the study are described and discussed in chapters 5, 6, and 7.

4.2 The Design of Research

Choosing the appropriate research design depends on several factors, including the research question, the nature of the phenomenon being studied, the availability of resources, and the goals of the research. For the purpose of this thesis, the qualitative design was selected as the objective of the study is to investigate the experiences of immigrant women working in Finnish healthcare. Qualitative research can provide a rich and nuanced understanding of complex phenomena and can be particularly useful in exploring sensitive topics or contexts where quantitative methods may not be appropriate (Tracy 2013).

Qualitative research methods such as interviews and observations allow researchers to collect rich, detailed data about participants' experiences and perspectives. Qualitative research emphasises the importance of context and diversity, allowing researchers to understand how social, cultural, and historical factors influence one's experiences. It often involves participants as active collaborators in the research process, allowing their voices to be heard. It can also help to develop new theories and hypotheses by exploring complex phenomena in-depth. (Creswell & Poth 2018.)

In this thesis, the in-depth interview method is justified to reveal the questions at hand. This study aims to reveal common phenomena through the perception of the participants.

The social and health sciences make substantial use of phenomenology, particularly well adapted to understanding several people's shared experiences with the same event. In this study, the women have shared similar transitions in their private and professional lives, it is befitting to incorporate phenomenology to capture the lived experiences. The concept of phenomenology is introduced in the following chapter.

4.2.1 Understanding Phenomenology

Phenomenology is a philosophical approach that involves exploring the subjective experiences of individuals to gain a deeper understanding of a particular phenomenon (Cerbone 2006). In psychology, phenomenology is often used to study the lived experiences of individuals in various contexts, including mental health, education, and social relationships.

German philosopher Edmund Husserl, the founder of phenomenology, emphasised the importance of bracketing or setting aside preconceptions and focusing on a person's own experiences. Husserl's work laid the foundation for further developments in phenomenology, including the work of Maurice Merleau-Ponty, Jean-Paul Sartre, and especially Martin Heidegger. (Hammond, Howarth & Keat 1991.) While there are some differences between Husserl's and Heidegger's approaches, both emphasise the importance of studying the subjective experiences of individuals.

Husserl's approach to phenomenology is rooted in the idea of intentionality, which refers to the directedness of consciousness towards objects in the world. According to Husserl, consciousness is always directed towards something, and the study of conscious experience should focus on the intentional structures of consciousness. Husserl's goal was to develop a rigorous method for analysing conscious experience and uncovering the fundamental structures of the consciousness. (Hammond, Howarth & Keat 1991.)

Heidegger, on the other hand, rejected Husserl's focus on consciousness and intentionality and instead focused on the idea of "being in the world." For Heidegger, the fundamental way individuals experience the world is not through consciousness but through their existence. Heidegger believed that the study of human experience should focus on the ways in which individuals exist in the world and how their understanding of the world is shaped by their existence. (Hammond, Howarth & Keat 1991.)

Phenomenology has also been used as a method for research (Nakayama 1994). There are two types of phenomenology used in research: Descriptive and interpretative. Descriptive phenomenology is focused on describing the essential structures and features of the phenomenon being studied, with the researcher's suspension of preconceived notions and assumptions. Interpretive phenomenology involves explaining and analysing the meaning of a phenomenon based on pre-existing knowledge and theoretical perspectives.

Conducting in-depth interviews is one of the most common methods of data collection in phenomenological studies (Lester 1999). In these interviews, researchers ask open-ended questions to let interviewees describe their feelings and experiences in detail. In this study, the researcher is actively participating in the interview, thus creating the interpretations together with the participants. First, each interview is individually analysed, followed by a comparative analysis (Marshall & Rossman 2016) to delve into the core of the phenomena. Data analysis is described in more detail in chapter 4.5

4.3 The collection of data

A semi-structured interview was used as a data collection method due to the study’s phenomenological approach and qualitative design. An interview was appropriate since the goal of the study was to capture the subjective experiences of the participants. Semi-structured interviews differ from conventional discussions by having a structure and predetermined questions to gain knowledge on the matter of interest (Kvale & Brinkmann 2009). They allow for flexibility in questioning while ensuring that certain topics are covered. The interviewer can also deviate from the script to follow up on interesting or unexpected responses from the interviewees (Bryman 2016).

Semi-structured interviews require skilled interviewers to ask follow-up questions and keep the conversation on track. Building trust between the interviewer and the participant is critical. This can involve initiating small talk, expressing interest in the informant's experiences, and demonstrating respect for their opinions. (Bryman 2016.) The participant's autonomy should be respected by giving them a chance not to participate in the study and by taking their feelings and preferences into account during the interview (Fontana & Frey 2008). The confidentiality of the responses should also be clearly stated to the participants, and the protection of their identities assured. Details of the interview should not be shared unless clear consent has been given (Bryman 2016). One of the

disadvantages of semi-structured interviews is that they are quite time-consuming. Multiple interviews must be conducted to gather a sufficient amount of data (Fontana & Frey 2008).

The data was collected by interviewing 10 women. The participants were free to choose the meeting place that felt most comfortable for them. Four of the participants were interviewed in a Café, two took place in a public library, and two were interviewed in their workplaces. Due to scheduling challenges, two interviews were conducted remotely over a Zoom video call. Thanks to modern technology and good internet speed, the video connection provided a means for the researcher to observe the participants' body language and emotions in a sufficient way.

Before the interviews, information on the study (Appendix 1) was sent to the participants, together with an informed consent form (Appendix 2). The data privacy was given in spoken following the contents of the Participant Information Sheet (Appendix 5). Prior to the interview, the participants were also requested to fill in a preliminary information form (Appendix 3) to make sure that the personal data, along with some general information, such as place of birth and education, were correct. The questionnaire guide (Appendix 4) was used as a backbone throughout all interviews. Although the questionnaire was quite extensive, it proved to use its purpose for some of the less talkative participants, while more active respondents covered many of the questions naturally without having to articulate them.

The purpose of the interview was explained, and confidentiality reassurance was given at the beginning of the interviews to build a comfortable environment. As the researcher shared some of the same experiences as the participants, breaking the ice and building trust was smooth and natural. Active listening techniques, such as frequent summarising and asking follow-up questions, were used to ensure the interviewee's thoughts were captured accurately and their feelings were acknowledged.

The interviews lasted between one and a half hours to two hours. All interviews were recorded with a smartphone to make sure that the researcher could fully focus on the participants. Participants may feel the interview was an uplifting experience (Kvale & Brinkmann 2009). It was delightful to see how some women felt that their voices were heard, their experiences mattered, and their efforts were respected.

4.4 The research sample

Planning the sampling for research involves making decisions about selecting individuals to be included in the study. Purposeful sampling is an important non-random technique that involves selecting individuals for the study based on a specific purpose or criteria. This type of sampling is often used in qualitative research, as the focus is on understanding the experiences, perspectives, or behaviours of a particular group of people. The researcher intentionally selects participants who are likely to provide rich and informative data related to the research question. This might involve selecting individuals who have a particular characteristic or experience that is relevant to the study or who can provide unique insights into the phenomenon being studied (Tracy 2013).

The combination of both convenience sampling and snowball sampling was used in this study. Convenience sampling involves selecting individuals who are easily accessible from the researcher's network and available to participate in the study. Snowball sampling, also known as referral sampling, involves selecting participants based on referrals from other participants. Researchers might begin by recruiting individuals with a particular characteristic or experience and then ask them to refer others who may also be eligible for the study (Goodman 2011).

The researcher has contacted individuals from her personal network, providing short information on the study via email or text. The individuals were also asked to recommend somebody from their network if they felt this person could contribute to the research and would be interested in participating. To those individuals, who showed interest, the researcher asked them to shortly introduce themselves by writing a small message about their home country, work experience and education. Based on the information provided by potential participants, the final decision on the meeting and interview was made. The key requirement criteria for the participants were:

- Middle-aged woman, first-generation immigrant (born and grew up in other countries than Finland)
- Currently employed or was employed in the Finnish healthcare

Second-generation immigrants have been excluded from this research as, being born and growing up in Finland, they experience different types of transitions and challenges.

The EU citizens have also been excluded from this study, as the recognition of the previous studies process and job opportunities are very different compared to the non-EU immigrants.

A reasonable variation in a research sample refers to the degree of diversity or heterogeneity among the individuals in the study. It is important to have reasonable variation in a research sample, including individuals from different age groups, ethnicities, socio-economic statuses, and geographic regions (Shadish, Cook & Campbell 2002). The researcher influenced the sample variation by ensuring that immigrant women from different origins, backgrounds, ages, education, and workplaces were included in the study.

In this study, ten immigrant women were interviewed. All were first-generation immigrants who moved to Finland for education or family reasons between 1995 and 2014. Four participants were from the Northern and Central regions of Africa, four were from the former republics of the Soviet Union, one was from the Middle East, and one was from the Far East. Half of the participants had a degree or had studied in healthcare before moving to Finland. These occupations included nurse, doctor, speech therapist and psychologist. All participants got a healthcare degree in Finland and are, or have been, employed as doctors, registered nurses or practical nurses. All participants are married with children. Everyone speaks Finnish and English in addition to their mother tongue.

4.5 The analysis of data

Smith (2015) describes interpretative phenomenological analysis (IPA) as "a qualitative research approach concerned with understanding the lived experience of participants in a particular context." IPA aims to understand the subjective experiences of individuals by exploring their lived experiences, perceptions, and interpretations of a particular phenomenon. IPA is based on the philosophical framework of phenomenology, which emphasises the study of human subjective experience; hermeneutics, which is concerned with interpreting the meanings; and idiography, which emphasises the uniqueness of individuals (Tuffour 2017). Phenomenology provides a framework for exploring the participants' subjective experiences, and hermeneutics provides a means of interpreting and understanding the meaning and significance of those experiences. The idiographic approach contributes to IPA's theoretical foundations as it emphasises

the uniqueness of individuals and seeks to understand the complexity and richness of individuals in depth before drawing broader conclusions (Pietkiewicz & Smith 2014).

IPA was chosen as an analytical approach for this study as it complements the already outlined interpretative phenomenological approach. IPA entails a thorough examination of data gathered using semi-structured interviews. The analysis involves a systematic and iterative process of coding and interpreting the data to identify themes and patterns that emerge from the participants' experiences. The researcher aims to capture the essence of the participants' experiences, gain a deeper understanding and explore the meaning and significance of these experiences in their lives.

IPA is a flexible qualitative research approach that can be used in various settings and with different research questions. By allowing the interviewees to express themselves in their own terms, IPA can provide rich and nuanced insights into how people make sense of their world (Pietkiewicz & Smith 2014). It is often used in psychology and healthcare research to explore various topics, such as mental health, chronic illness, and caregiving. It is also used in other fields, such as education and sociology, to gain insight into how individuals perceive and interpret various aspects of their lives (Tuffour 2017).

However, like any research approach, IPA has its limitations. IPA focuses on exploring the subjective experiences of individuals and may not provide a comprehensive understanding of the broader social and cultural context in which those experiences occur. This limitation has been noted by some researchers, who argue that IPA may be more appropriate for exploratory research rather than explanatory research (Pietkiewicz & Smith 2014).

There is no standardised approach to conducting IPA, making it difficult to compare findings across studies. This limitation has been acknowledged by proponents of IPA, who argue that flexibility and adaptability are important in ensuring that the method remains responsive to the needs of researchers (Smith 2015).

While IPA has limitations, it remains a valuable approach for exploring the subjective experiences of individuals in depth. By being aware of these limitations and taking steps to mitigate them, researchers can use IPA to generate rich and nuanced understandings of the phenomena they are studying. For example, Smith (1999) has utilised IPA in

related situations when examining transitions. Hence, in the framework of this thesis, the choice of IPA seems acceptable and suitable.

In this study, all interviews with participants were recorded. Transcribing the spoken words captured during the conversation into a paper is a critical step in data processing and analysis. Marshall and Rossman (2016) emphasise the importance of accuracy, attention to detail, and adherence to a consistent transcription style when transcribing research interviews. They suggest that transcription should be viewed as an essential component of the research process and that careful transcription can lead to a richer and more nuanced data analysis.

A semantic level of transcription is often used in the IPA to capture the meaning and essence of participants' experiences. According to Smith (2015), a semantic level of transcription involves capturing the participant's exact words while also highlighting the underlying meaning and themes behind those words. This level of transcription allows for a deeper understanding of the participant's experiences and the phenomenon under investigation.

In addition to capturing the participant's words and meaning, it is also important to annotate the transcript with notes on nonverbal cues and other contextual information that may be relevant to the research question. According to Larkin, Watts and Clifton (2006), "the recording of detailed notes about the context of the interview and the nature of the interviewee's responses is critical to the success of this method". These annotations and notes help to provide a richer understanding of the participant's experiences and the phenomenon under investigation. When citing the participant's words in the transcript, it is important to do so accurately while providing interpretation and analysis. It is essential to use interviewees' own words to support the themes but also to provide an explanation and analysis of the data (Smith 2015).

In this study, during the transcription, all the words, tone of voice, pauses, tears, and laughs of the interviewed women were documented. After the transcription, the researcher read and reviewed the transcripts multiple times, paying close attention to the meaning behind the words spoken by the participant. The first data analysis started at this stage (Smith 2015) by noticing insights, analogies and discrepancies. As the researcher read and reviewed the transcripts, the key themes and concepts that emerged from the participant's experiences were identified (Marshall & Rossman 2016).

Next, the researcher used coding to organise and analyse the data. Transcriptions were organised according to the themes. Further interpretation and analysis were completed by breaking down the themes into subcategories in the frame of TLM and self-efficacy concepts, including linking the categories and finding reasonable explanations and insights. Lastly, the themes were converted into narratives, explained and justified by quotes.

4.6 Considering the ethics and quality

Qualitative research involves the exploration of complex human experiences and phenomena. It is vital that ethical principles and guidelines are followed to ensure respectful and responsible conduct of research. Informed consent, confidentiality and anonymity, minimising harm to participants, and reflexivity are key ethical considerations to be taken into account in the qualitative research (World Medical Association 2022). It is essential to protect the participant's rights and to maintain high integrity throughout the whole research process. (Finnish Advisory Board on Research Integrity 2012: 30.)

Participants should be provided with information about the research, its purpose, and its potential risks and benefits. They should have the right to decline participation or withdraw from the study at any time without consequences. Researchers should ensure that participants' identities are protected, and their data is kept confidential. Researchers must also take measures to prevent the identification of participants in the research outcomes. They should consider the potential consequences of data breaches and mitigate them. Minimising harm to participants involves assessing the potential risks of participation and providing support services and referrals to resources when necessary. Reflecting transparently on the researcher's own position, biases, and assumptions and how they may influence the research process and outcomes. The researcher should acknowledge the limitations of their own perspective.

In this study, the participants were given information on the study (Appendix 1). Data privacy was given in spoken form following the contents of the Participant Information Sheet (Appendix 5) and was discussed in great detail. The informed consent form was signed, and confidentiality was ensured, as described in Chapter 4.3. No names of the participants were used, and places of work were mentioned to ensure the subjects were unidentifiable. A short description of the participants in Chapter 4.4 was kept at a minimum. Not offending or harming the participants was considered in every study step.

The subjects were given a chance to choose a comfortable location for the interview, and the questions were formulated mindfully. All interview materials are stored in a secure location that only the researcher can access. After the thesis process comes to completion, all material will be stored securely for 5 years according to the EU GDPR regulations.

To maintain integrity, the study was carried out honestly and responsibly at all phases, including design, data collection, presentation, and evaluation of the study's findings. It has been acknowledged that there was no necessity for research permits or ethical evaluations. The study participants have been informed of the researcher's status, rights, duties, and obligations. The work of other scholars has been appreciated, and proper citations have been included throughout the thesis.

Reflexivity can be considered both an ethical and a quality measure. It involves critically reflecting on the researcher's biases, values, and assumptions and how these may impact the research process and findings (Tracy 2013). In this thesis, the researcher acknowledges having an immigrant background herself. It may influence the research process and the results. This may manifest itself by relating to the subjects' stories well, sometimes in a too-sensitive way for both pain and success. The researcher has a marketing education and work experience with analysis of qualitative research and analysis of data; thus, she has done her best to both relate to the subjects and be beyond the situation while analysing the data. However, in qualitative research, bias is always present to some extent, as the researcher can be considered as the research instrument (Lichtman 2013).

Marshall and Rossman (2016) discuss the positionality of the researcher, which refers to how the researcher's identity, beliefs, and social location shape their perspective and influence the research process and findings. It involves recognising that researchers are not neutral and objective observers but active participants who bring their own biases and perspectives to the research process.

According to Yardley (2000), there are several important quality aspects to be considered. **Sensitivity to context** involves understanding the cultural, social, historical, and political contexts that shape the experiences and perspectives of research participants. **Commitment** involves having a clear and well-defined research question, a sound theoretical framework, and a commitment to trustworthy and meaningful data

collection and analysis methods. **Rigour** involves paying attention to the details of the research process, including appropriate sampling strategies, rigorous data collection methods, and systematic data analysis procedures. **Transparency** means that the research process and findings are clearly and transparently reported. **Coherence**, on the other hand, refers to the extent to which the findings are logically consistent and make sense in relation to each other. **Impact** refers to having a meaningful and lasting difference in the lives of the participants, the researchers, and the wider community. Lastly, significance or **importance** refers to producing essential and relevant findings that have the potential to influence policies and practices.

All the above dimensions have been thoroughly considered during the entire process of this thesis. The research question was carefully chosen to be clear, relevant, and important. Appropriate research methods were selected based on the research question. Sampling, data collection, and data analysis were conducted with appropriate methods and with rigour. The researcher considered the cultural, social, and political factors that may impact the study and its findings. Ethical considerations were taken into account as described earlier in this chapter and the research process and results have been described transparently.

5 Results

This chapter will introduce the findings and conclusions of the research. First, the different transitions immigrant women encountered on the way and within the Finnish healthcare system are analysed. The factors that influence the transition and the impact of the transition on individuals will be discussed. The key challenges and success factors individuals face during the transition will be studied in a separate subchapter.

5.1 Transitions

The transitions immigrant women experience within their career paths in Finnish healthcare could be divided into three stages: entry, maintenance, and exit. These include all five transitions defined by Schmid (2001). At the entry point, there are multiple transitions, such as relocation to Finland, developing language skills, recognition of previous studies or reeducation, transitioning from one occupation to another, from studies to work and unemployment to employment. The maintenance stage includes transitions between different types of employment: internship or practice and paid work,

career advancement, part-time to full employment, and from childcare back to work and studies. The exit stage, in the context of this analysis, means exiting the healthcare sector, not the labour market i.e. transitioning to another sector of employment. Transitioning to retirement was absent in this study due to all participants being part of the labour force. Transitions that immigrant women experienced before relocation to Finland are not included in this study.

5.1.1 Relocation to Finland

The origins of the women in this study vary, but they are all from countries where they have had the opportunity to live life to the full. All women were relocated because of their partners or studies in Finland and united by the desire for change, curiosity and striving for better. Even though it was a desired relocation and weighted decision, all experienced mixed emotions and challenges as they adjusted to a new culture and way of life. Maintaining connections with their country of origin through various means, such as communication with family and friends, remittances, and visits back home, helped to maintain a sense of belonging and identity with their country of origin, even as they established new relationships and connections in their new home. All immigrant women recognised that the process of migration and relocation is not a one-time event but rather an ongoing process of negotiation and adaptation to new cultural and social environments. The uniting factor for all participants was that despite the desired changes and smooth transition, the changes were very drastic and difficult. All women moved to Finland in adulthood, leaving relatives and friends, jobs and social statuses, and restarted their lives. However, none of the participants regrets relocation. Some participants mentioned the probability of moving to another country within the EU, believing they could earn more than in Finland but not returning home. Feeling that they do not belong to their home countries anymore and are not fully accepted in Finland at the same time creates a small but rather constant feeling of uncertainty and instability. Growing children in Finland and their future are also strongly pronounced motivations to stay.

> I met my love in Finland. We had a warm and romantic relationship. /…./ We got married. It was an adult decision to relocate to Finland. I was sure it was a change for the better. I was getting myself ready. I started to learn Finnish already at home. /…./ in the end, I had to start everything from scratch, which was really difficult. (Participant)

> I was enthusiastic and optimistic in my first years in Finland, but lately, the reality hit me /…/ I was missing home, my job, friends, everything /…/ God!

> It was such exhausting years /…/ Studies /…/ Work /…/ Children /…/ Now I really feel proud of myself /…/ In the end, I did it! (Participant)

> It was quite easy to come to Finland when my man got a job, everything went well. /…/ Really, it was a lot harder than we expected. We were really settled at home. Both my man and I had good jobs, and moneywise we were OK. We lost it here. Completely, at least in the beginning. /…/ It is slowly getting better, but I think it never comes back completely, you know /…/ We do not want to return; we want our children to grow up and live in Europe… (Participant)

> I see myself staying in Finland because of my kids and family. Probably, without family attachment, I would move to an English-speaking country. /…/ I put so much effort into studying Finnish. What if I invest this time in something else? (Participant)

All participants had experienced success before relocating to Finland. According to Bandura (1977), one of the significant high self-efficacy resources is mastery or past experiences. Self-efficacy affects one's aims, ambitions, and stress resistance when coping with change. It also influences how an individual thinks, adapts and develops. By showing high resilience, the participants were able to overcome the challenges. With having high self-efficacy to begin with, these women managed to revive declined self-efficacy during the relocation challenges.

5.1.2 Developing language skills

Mastering the Finnish language is the first transition in Finland that all women in this study have encountered. Participants recognise that language learning is a critical part of their career path in healthcare. It is a process that takes time and ongoing effort. Even after they become proficient in the Finnish language, there may be ongoing challenges and adjustments as they continue to navigate linguistic and cultural differences. Under the TLM theory, language learning can be viewed as a life-long transition and adaptation to new cultural and social environments (Schmid 1995). Women working as nurses shared that it was rather easy to achieve the required language skills to be accepted to nursing studies. Still, they experienced a lot of challenges and frustration with language during their studies, internship, and work. However, those applying for other medical studies found the language requirements challenging or unreachable.

> I really put much effort into learning Finnish /…/ during my nursing studies I had a very bad experience. I did not understand my supervisor. They put me off practical training because of my language skills. /…/ I felt so bad, even offended /…/ How can I practice the language if nobody is talking to me? (Participant)

> It took me 6 years of constant learning to finally meet the requirements and get accepted to the University for my medical studies. (Participant)

> They told me I needed a C1-C2 level to reconfirm my diploma /…/ I studied /…/ I tried to pass the exam several times but failed… (Participant)

> When I finished my nursing studies, I could start working as a sairaanhoitaja right away, but I had a fear of responsibility, I was afraid I would not understand something and fail /…/ I worked 3 years as lähihoitaja, practised Finnish, and then changed job… (Participant)

5.1.3 Recognition of previous studies / Re-education

The recognition of previous studies and qualifications was an important aspect of the transition process for all participants. Some have prior education and experience in healthcare, but these credentials were not fully recognised in Finland. The process of recognising prior studies and qualifications varies widely depending on the specific field of healthcare. In some cases, participants needed to complete additional training and language exams to meet Finnish standards. In other cases, prior education and experience were recognised partially, and there was a need to go through the education process. Navigating the process of recognition was challenging for all participants, particularly while facing language barriers and difficulties in understanding the requirements. Some participants mentioned that lack of recognition could be demoralising and frustrating, creating the feeling that their skills and expertise are undervalued.

Women working as nurses describe this experience more positively compared to others. Even though they had partially to redo all their studies and they had a feeling of being undervalued in the beginning, later they saw it as a needed and important step in understanding the Finnish healthcare system and procedures and practising the language. They also describe getting into the studies as easy, accessible, and transparent. While women with other specialities and with higher levels of education have more negative experiences. The main challenge for them was the high level of language requirements. Even if they are fluent in the language, they may not be as confident or culturally aware as native speakers, which can impact their ability to perform well. This postponed the recognition process or reeducation for years and, for some participants of this study, made it impossible. De-scaling and feeling undervalued were the major themes coming out throughout all stories.

> I already had a registered nurse diploma, but the TE office strongly recommended going to lähihoitaja. They did not care that I was saairanhoitaja. I went to nursing school, which I chose myself, and because of that, I partially lost TE's financial support. /…/ I did some exams. /…/ At school, I informed the principal that I was already a professional nurse, so it took me less than two years to graduate; it was a relief… (Participant)

> It was easy to get in, and the language test was not very difficult /…/ I do not see any problem /…/ with this process…(Participant)

> I was informed that I need only 200 hours of training to confirm my diploma as a speech therapist. /…/ In the beginning, I was sure I could make it. I never thought I could work with Finnish clients, but I could help Russian-speaking children. I know there is a need for professionals with the Russian language /…/ But I could not make it because I did not meet the language requirement despite all my efforts. (Participant)

> I have been trying to get into the university for several years. It took me 6 years of constant learning to finally meet the requirements and get accepted to the University for my medical studies. The studies were not difficult, as I already have a degree from Russia. The practical part was very intensive and challenging but also interesting. I am happy and proud that I did it. I love my job. But it took me more than 10 years to get there, and it was not an easy journey /…/ (Participant)

5.1.4 From other occupations to healthcare

In this study, some women decided to start their careers in healthcare after moving to Finland, while at home, they had other educations and jobs. In their stories, they had felt a calling to help people long before; however, they did not choose this path in their home countries. In Finland, this decision was motivated generally by the fact that they did not see the opportunity to continue the path they had started earlier. The entrance into the occupation they had at home seemed to be too difficult, and some of the participants failed to implement it, and some did not even try. Healthcare, particularly nursing, was attractive due to employment possibilities and personnel shortages. Entering the nursing schools seemed to be a transparent process with clear and reasonable requirements. Free-of-charge education in Finland was the final factor in the decision to change the occupation.

Transitioning from one occupation to another was challenging; in a new cultural, social and language environment, they were also moving to a new professional field with different employment opportunities and requirements. However, with the right support and resources, women successfully transitioned to a new occupation and found meaningful employment. It is important to mention that women with higher levels of

education experienced more frustration, feeling hopeless and humiliated. They struggle to maintain self-respect and dignity.

> I studied business and worked in real estate, but when I came to Finland, it was clear I had a low chance in this field /…/ My mother-in-law pushed me to nursing, and now I have a profession with guaranteed employment. Studies were really difficult and exhausting. New language, medical field! OMG! I would not do that again! /…/ I am so lucky that I studied dental care /…/ Healthcare is a different world, I have renewed myself completely, but I like my job… (Participant)

> I am a psychologist /…/ In Finland, I did not dream of going in this direction. I was realistic /…/ I wanted to continue to work with people. Nursing seemed logical, and what was also important, it was doable /…/ At that step, I wanted to get a job, even though it was not the level I was before… But it was before… Who cares /…/ And still, that's better than cleaning… (Participant)

> When I failed to recognise my speech-therapist's diploma, I tried several jobs as a babysitter, but it was unstable job and income /…/ I was looking for a stable income and guaranteed job /…/ It looked like studying nursing is a good option /…/ I could manage my studies, but when it came to practice, I had the impression that I could not make it. It was difficult mentally and physically. I was not appreciated both by personnel and patients… (Participant)

5.1.5 From studies to work

Women's stories revealed that education, in most cases, smoothly leads to employment. Most participants managed to establish themselves during the study practices and were invited by employers after graduation; in some cases, networking and looking for vacancies also worked smoothly. All participants mentioned the demand for healthcare professionals – a Finnish degree and the Finnish language open the doors.

> The studies were challenging, but the practice part sometimes seemed unbearable…You are totally lost in the process, language, everything /…/ But it was getting better… I took an extra year of studies, which helped me take over /…/ My last practice, surprisingly, was not so difficult, I even started to take extra shifts /…/, I stayed with this employer after graduation. (Participant)

> During the study practice, we were already invited to come for work after graduation /…/ (Participant)

> Demand helped to find a job. (Participant)

5.1.6 From unemployment to employment

A few participants experienced unemployment after graduation from nursing school. However, the experience of job-seeking was positive. All women have been self-confident in the possibility of finding a job in the nearest future and mostly were dedicating this time to family, kids or travelling back home to help their parents. All women were united in the opinion that overcoming challenges in study and work creates confidence and certainty in tomorrow, although, of course, this is a very long road, and the price is hard work and sleepless nights.

> It was not difficult to find a job, it just took a while… Now I work in one of the biggest hospitals… (Participant)

> It is more or less difficult to find a job depending on the specialisation, but overall, there is enough work in healthcare for everybody. (Participant)

According to the TLM theory, unemployment is not considered a negative state in one's career but rather a transition in preparing for the next career move in one's professional life (Schmid 2001). Most of the women in this study had moments of hopelessness and feelings of failure or inability to move forward. However, during unemployment, they showed self-confidence to use this time for meaningful activities. This can be explained by high self-efficacy, developed before facing unemployment and empowered them to treat it as an enabling step for the next transition.

5.1.7 From a part-time job to full employment

Most women in this study initially took on various part-time jobs while they studied language and healthcare studies. These jobs were in healthcare, such as personal care aides or home health aides, and outside healthcare, such as personal assistance or cleaning. This experience was exhausting, stressful and distracting from the key studies; however, it was necessary to keep up with the financial situation in the family. As immigrant women became more proficient in the Finnish language and healthcare studies, they started to pursue part-time employment opportunities in healthcare, such as taking additional shifts during the practice or working in elderly homes. With experience and continued education, immigrant women were able to advance to higher-paying and more specialised roles in healthcare, such as registered nurses or practical nurses. Throughout these stages, immigrant women faced various challenges, including language barriers, discrimination, and lack of appreciation and respect. However, with

perseverance and fortitude, immigrant women transitioned from part-time to full-time employment and achieved their career goals.

> I worked in cleaning while learning Finnish, and when I started nursing school, I kept it part-time. Otherwise, we would not survive. It's a pity the study practices are not paid. Even a small compensation would help students to meet their ends /…/ That will also be a good motivation; in most cases, it is very demotivating. Nobody appreciates us, supervisors, or patients. (Participant)

5.1.8 From childcare back to work and studies

Children are incredibly important in the lives of women in this study. Children provide a sense of family and emotional support and a sense of belonging, which is particularly important as they often feel isolated. It is very important for women to have time and the possibility to teach their children their language and traditions to ensure that their cultural heritage is passed down to the next generation. Children represent the future, and by investing in their children's education and well-being, immigrant women are investing in the future success of their families and communities. Therefore, the transition of women from childcare back to studies or work relates to stress, feeling guilty and emotional burnout. All women highlighted the importance of partners in this process, and most of them mentioned that it would be impossible to do it alone. The most challenging and exhausting time was combining studies, night shifts, and small children. At the same time, children for these women are a motivator to success. Most women work hard to provide for their children and to give them opportunities that they may not have had themselves. The desire to provide a better life for their children was powerfully pronounced in all women's stories.

> It was so hard, sometimes I thought it would kill me /…/ My motivation is my children. You have to work to survive… (Participant)

> I felt so guilty that I could not spend enough time with my child during my studies. Thanks to my husband, we survived. But during the night shift, I could only think about my baby crying at home… (Participant)

> When I graduated, I decided to spend one year at home with my child without the night shift… I did some gig jobs, but thanks to my husband, we could afford it. (Participant)

> In Finland, you can take your child to päiväkoti quite early /…/ It helped so much /…/ Otherwise, I couldn't study or graduate. (Participant)

Most women were satisfied with the Finnish daycare system, which helped them to balance studies, work and children. According to OECD (2022), a well-functioning childcare system is critical to women's labour-force participation. The TLM theory aims to take both individual and institutional levels into account while developing policies (Schmid 2001). From the stories of women, it can be seen how an accessible childcare system empowers women and enhances their transitions.

5.1.9 Career advancements

Despite being a growing part of the healthcare workforce and education in Finland, immigrant women were only able to achieve certain levels of positions. Among the challenges were language barriers, cultural differences, discrimination, and a lack of access to mentorship and networking opportunities.

Communication is crucial in healthcare, and healthcare professionals must communicate effectively with patients and colleagues. All immigrant women faced challenges in mastering the nuances of the Finnish language, which for some period limited their ability to build relationships with patients and colleagues. However, mastering the language did not bring more recognition and appreciation, and they felt ignored.

Discrimination in its various manifestations was a clear obstacle to career advancement, despite significant efforts and constant learning. Immigrant women faced prejudice or bias from patients or colleagues, they believed they had to work harder than their native-born counterparts to prove themselves and gain recognition for their skills and expertise.

In this study, immigrant women managed to overcome challenges, establish themselves at certain levels and experience greater stability in their employment and financial situation. However, they constantly have a sense of isolation or dislocation. Limitations in their ability to advance their careers and take on higher-level positions were described as humiliating and demoralising.

> I am a registered nurse, and I have worked in Finland for several years, but some supervisors still do not believe in my capacity and abilities. Some tasks that belong to me they assign to my junior Finnish fellows with less experience without even informing me /…/ I'm stuck with same simple tasks all the time /…/ Of course, it offends me, and I feel awful /…/ I never discussed it or confronted my supervisor, I do not think it will help me or change something. (Participant)

> People make conclusions and feelings based on your skin colour /…/ They ask to be attended by a Finnish nurse, they believe they are better /…/ I just stay on my ground and try to do my best. (Participant)

> When patients call to schedule an appointment with a doctor and hear a foreign name, they prefer to change the day and go to the doctor with a Finnish name. (Participant)

> Nobody thinks I am a foreigner at first sight. But when they hear my accent, I can immediately see suspicion on their faces. /…/ And it is so important to ask where I am from. Does it really matter? And based on my country of origin, they make conclusions about my professionalism? /…/ I worked hard on my language skills, and my accent is minor, but this is not enough. /…/ With so many years of experience, I moved to some supervisory tasks. But I do see that Finnish nurses get there quick, while for me, it was almost 20 years. (Participant)

> There are many challenges at work and mistrust, which is not verbal, but I see and feel it every day. Let’s not discuss it. It will take hours. /…/ In 5 years, I want to see myself achieving my career aspirations; however, now…, mission impossible. (Participant)

5.1.10 Exiting the healthcare sector

Some participants, after several years in the profession, decided to change their occupations. Even though they appreciated the meaningful jobs they had and the efforts they invested to achieve them, they did not see the opportunity for career advancements in healthcare. They were looking for more radical changes in responsibility, opportunities, freedom to make decisions on the job, and flexibility. The challenge these immigrant women experienced could be called the "brain waste" phenomenon, where their qualifications and skills were not fully recognised or utilised. They had chosen education and jobs below their skill level and ambitions. However, studying and working in healthcare was an important step in their careers, which helped to settle in a new home, master the Finnish language, and get a stable job. And even more, it became a platform for growing self-esteem and future ambitions. Night shifts and compensation were also mentioned among the reasons for leaving the healthcare sector. The women continued their education and careers in the areas close to healthcare.

> I decided to leave nursing after so many years because I wanted to do more. I felt I could do more than follow instructions /…/ But work in nursing was my bread for a long time, and most of my friends are still there /…/ My nursing experience now is essential in cosmetology. (Participant)

> Probably, lähihoitaja was not the right decision, but I was desperate. I needed a job to make ends meet /…/ Later, I studied pedagogy, and it is a better usage of my previous experience… (Participant)

5.2 Key Challenges and Success Factors

The healthcare segment has its own specific characteristics that don't affect other labour markets. First, the entrance to the segment for non-EU immigrants goes only through language education and skills transfer, which in most cases means reeducation. Mastering the language is specifically important in healthcare. While in other segments, there is a possibility to get a job without the Finnish language or basic knowledge could be enough, healthcare professionals must communicate effectively with patients and colleagues. There is no room for mistakes and misunderstanding as it concerns patients' safety, and effective communication is crucial. As a result, entrance into the healthcare sector takes exceptionally long and requires a lot of effort and years of study. The language barrier and understanding the mentality and the system require time; making a fast track is almost impossible.

Free education in Finland, with no age limitations and guaranteed employment, attracts immigrant women without previous healthcare education and experience into the sector. This is a unique opportunity to start a new life and get an education and a meaningful job. A diploma in the home country makes learning in Finland easier, but recognising previous studies is often associated with descaling and the inability to continue or advance a career in a logical path. There is a tendency to assign immigrants to jobs requiring lower qualifications than they already have from their home country. A registered nurse could be steered to study for or take a job as a practical nurse.

In healthcare, language learning can be viewed as a life-long transition and adaptation to new cultural and social environments. It is a process that takes time and ongoing effort. Even after immigrant women become fluent in the Finnish language, there may be ongoing challenges and adjustments as they navigate linguistic and cultural differences. As was found in a study conducted by Tricia Cleland Silva (2018), a confident command of the Finnish language was not enough to remove obstacles of being an immigrant. One of the participants in this thesis study reflected on the topic "What would it require to be accepted by Finnish society?". Her language skills were fluent enough to get citizenship in Finland and to participate in all the elections. However, still, at work, she is rejected by some native-speaking patients and colleagues.

> Despite all your efforts, you are always seen as an immigrant. (Participant)

These feelings also concur with the study made by Maire Antikainen (2010). It also proved that having received Finnish education and speaking the language, immigrant women were not able to advance in their careers.

The unwavering desire of immigrant women to put down roots in Finland and stand on their own feet is a hallmark of this study. Strong will, patience, and an amazing ability to ignore or not notice challenges on the way to their goal helped them build their careers. All the women spoke about the difficulties, the unpleasant experience of discrimination, and the feeling of rejection. Some talked about it openly and straightforwardly, some in between the lines or with facial expressions. The women were discriminated due to speaking with an accent, having a foreign name, or their appearance and looks. Despite the huge difference in origin, mentality, and different grounds for discrimination, women lived through this experience almost the same way - with the help of detachment, trying not to notice and moving on. In fact, they were ignoring discrimination, pretending they did not understand or see. But it is very important not to make a wrong conclusion here. They were not weak to react, protest or give an answer. But their answer was to show society they could do this job at a high level, with dignity and professionalism. Most of them mentioned that if they would let themselves ponder on it for too long, they would waste their energy and would not be able to continue their paths. This position should not be seen as ignorance or hiding the problem. Since the study involved women who built their careers and found their own path, we can say that they directed their energy towards achieving goals and, throughout their journey, tried to look at the situation only from the position of “the glass is half full”.

Local language skills, a diploma from Finland and the healthcare workforce labour shortage open doors to employment. However, it does not guarantee acceptance or respect from the community. Immigrant women work in isolation. There is a lack of appreciation from the patients, co-workers, and supervisors.

> I have studied nursing the same way as Finnish nurses, and they still don’t trust me… Does that mean that they don’t believe in the Nursing education system in Finland? (Participant)

Immigrant women are often overlooked for promotions or career advancement opportunities due to stereotypes, prejudices, or biases. They had to put forth more effort than their peers who were native-born to establish themselves and get respect for their

knowledge and abilities. The higher the education of women, the more often the question arose about the “social capital” left behind in their homelands and their abilities to utilise the potential. A huge amount of time is spent simply on mastering the language and building social networks and trust. Ulrike Scheffer (2019) argues whether the migration of skilled personnel makes sense if it takes years to integrate. And perhaps, the second generation should be in focus, as according to experience, they can be fully integrated into society.

Long education is also connected with a potential need for support. All the interviewees were vocal about the support of their partners or other people in their social network. Without their help, and financial aid, they would not have completed their studies. Some participants had to take part-time jobs outside of healthcare to cope with the daily financial demands. For most women, it was a struggle to balance life and financial matters while having night shifts at practice, studying during the day, and having a family and children. None of the women would have been able to go through many such transitions simultaneously without their partner’s support.

The meaning of family and children is twofold for immigrant women. On the one hand, they are a challenge draining energy and resources, but on the other hand, they are the greatest motivator to move on and work hard. This derives from seeing the role of a woman in the traditional way and overemphasising the role of the children in their lives. Being isolated in a new country and losing social connections, children represent emotional support and a sense of family. Women want to spend more time with children, teach their language and traditions, and pass on cultural heritage. At the same time, they want to provide a better quality of life and more opportunities for their children, which is the strongest motivator to work hard and succeed.

What helped the participants to succeed? These women believed in their ability to achieve a goal. While living in their home countries, they had already established themselves. The dominant factor in relocation was not being forced to leave. Their previous success in their home countries built a steady ground for high self-efficacy. As they treated the relocation as a project or a new chapter, they naturally had high motivation, persistence, and resilience in the face of obstacles. It was their own decision to relocate. They turned the “social capital” in the home country into a source of strength and belief rather than something they lost.

High self-efficacy helped the participants to bounce back from setbacks and failures. While the descaling experience was very stressful, they still were able to find the strength to recover and move on. Even if their choices didn't create an expected outcome, they treated it as a steppingstone to the next chapter in their lives.

> If I look back, I see my nursing experiences as an important part of getting into Finnish society. (Participant)

6 Discussion

To answer the research question "What career paths have immigrant women in the healthcare sector taken?" it is important to note that it takes years to enter the healthcare sector for immigrant women. This is mostly because one must go through some re-education to be recognised as a healthcare professional in Finland. Additionally, one must learn Finnish at a fluent level, as the price of a mistake is patient safety. Entering the sector is a smooth transition after earning a degree and learning the language. However, on-the-job challenges are present. Lack of appreciation or discrimination from patients, colleagues and supervisors creates obstacles in career advancement and utilising the full potential of immigrant women.

Reflecting on immigrant women's paths in healthcare, five dominant themes emerged: experiences of cultural and linguistic barriers, access to training and education, occupational segregation, social networks, and strategies for overcoming barriers. These are the most significant enablers and obstacles in the transitions to and within the healthcare labour market.

Cultural and linguistic differences posed significant challenges to career transitions. Participants described feeling isolated, misunderstood, and undervalued in their new environment. This theme also highlighted the influence of socio-cultural factors, such as language, discrimination, and support networks, on participants' career transition and learning experiences. Without successful completion of this stage, there is no chance to move on in the path to healthcare. This is consistent with TLM theory, which suggests that significant life changes can lead to disorientation and loss and that cultural and linguistic differences can be barriers to a successful transition (Schmid 1998).

Education and learning played a critical role in the participants' career transitions. Women described how they engaged in various forms of learning, such as language

classes, reeducation, education and getting a new profession, on-the-job training, adapting to different healthcare practices, developing a new professional identity, and acclimating to their new workplace. This is also consistent with the TLM theory, which proposes that individuals go through a learning process during the transition and emphasises the importance of access to training and education in facilitating upward mobility (Schmid 1998). A high self-efficacy empowered immigrant women to complete their studies complying with the research by Pajares and Krantzler (1995) that self-efficacy is a predictor of academic achievement.

Occupational segregation refers to experiences of being involved in low-skilled and low-paid jobs within the healthcare sector due to language barriers, de-scaling, and discrimination. In this study, some participants were directed to practical nurse positions while having a degree as a registered nurse. A similar phenomenon could be observed in the study on immigrant Filipino nurses (Cleland Silva 2018).

Social networks emphasise the role of social connections and support networks in facilitating career transitions and access to job opportunities. Participants described the importance of family, friends, and colleagues in providing information, advice, and support related to their studies and career advancements. This strongly relates to verbal persuasion, one of the elements strengthening self-efficacy (Bandura 1977).

Strategies for overcoming barriers and adjusting to the new environment reflected interviewees’ efforts to adapt to their new workplace and overcome cultural and linguistic barriers. Participants named seeking out mentors, attending language classes, building relationships with colleagues, and ignoring discrimination as their strategic approaches. The combined success factors among the interviewees found in this study were motivation, persistence, and resilience when facing obstacles. Having a partner for support and children for motivation was observed to be an essential help on the way to achieving the goals. High self-efficacy, based on previous accomplishments, is a dominant factor in the success of the interviewed women. This is directly related to the self-efficacy theory (Bandura 1977), which proposes that positive past experiences are an ingredient in building high self-efficacy. In a further alignment with Bandura (1977), interviewed women viewed obstacles as challenges that could be overcome with effort and skill. They set ambitious goals and put energy into achieving them, took risks, and pursued new opportunities.

The relationship between life transitions and self-efficacy is that individuals' perception of self-efficacy depends on the success of transitions. Every transition is followed by a reaction and, eventually, an outcome. Confidence in one's skills and abilities creates high self-efficacy, while an unsuccessful transition may decline self-efficacy. To maintain a high self-efficacy, which is crucial in accomplishing goals despite obstacles, one needs to have a source of self-efficacy, i.e a way to recharge oneself. These include mastery experiences, past experiences, social persuasion, and emotional and physiological feedback (Bandura 1977). The women in this study were lucky to overcome all barriers and make their paths in healthcare as they had good sources of self-efficacy to keep them going.

6.1 Research Limitations and Future Research

The findings in qualitative research are not representative of the larger population (Marshall & Rossman 2016). However, qualitative research is intended to provide in-depth information about the experiences, perceptions, and perspectives of a particular group or phenomenon.

Measuring self-efficacy is not an exact science, as the wording of questions and the interviewee's mood and mindset at the time of measurement may influence the results. Thus, the researcher's interpretation of the data is subjective, and this can affect the reliability and validity of the findings.

Furthermore, the interviewees were chosen using the snowball process and based on their employment or prior experience in the field of healthcare. Coincidentally all women had a partner and children. This may influence the results of the research as the partner and children played a significant role as motivational and support factors. Further research on subjects without children and/or a partner could bring a wider understanding of immigrant women's career paths and success.

According to Kogan (2007), immigrants arriving from countries with less developed institutional structures compared to the destination country will not be able to transfer their skills as successfully as the one's arriving from countries with similar institutional structures. As immigrants from inside the EU are not part of this study, it would be interesting to see how the skill transfer of EU native healthcare workers differs from non-EU immigrants and affects their career trajectories.

6.2 Policy and Managerial Implications

Finland is known for being a strong welfare state and having a high-quality education system and progressive social policies, which reflect a commitment to promoting social welfare, equal opportunities, and gender equality. Finland provides excellent opportunities for immigrant women with permanent residence to start a career in healthcare.

Free-of-charge education with no age limitations provides the opportunity to start a journey in healthcare at any age, at any stage of a career and regardless of previous education. Finland's education in healthcare is well recognised within the European countries. Education in the healthcare field is available in both Finnish and English languages. Some participants in this study decided to change their profession to nursing, even though their first education was in a different field. All participants emphasised the high quality of education and the level of knowledge they attained.

Integration programs and language courses for immigrants are available to prepare for studies. Even though learning a language is the biggest challenge in the healthcare career path, every participant noted that the Finnish language learning system is constantly improving and providing quality knowledge. In most cases, language courses are free within the integration program or at an affordable price.

The developed childcare and early education system, as well as the right to have a maternity leave during your studies and work, provide the opportunity for women to plan their studies and careers without sacrificing their private and family lives. In this study, it was quite clear that for all women, reliable childcare was an important factor in reaching the goal.

One of the key elements of social policy in Finland is the social security system, which provides access to various benefits, as well as assistance for low-income families, including housing and social allowances. All immigrant women had financial support during their studies. However, considering the long period of studies in the healthcare field, financial support from the government was not always enough to support the family. Some participants were forced to take part-time jobs outside the healthcare. All women described this experience as exhausting, draining their energy and distracting from their studies.

While there is always room for improvement, the social policy in Finland supports and provides opportunities for immigrant women living in Finland to start a career in healthcare. Unfortunately, there are difficulties in the workplace after the long journey to the goal. Immigrant women face barriers to job progression and maximising their potential due to a lack of recognition or prejudice from patients, coworkers, and supervisors.

The two main themes that emerged in this study were overall respect for care professions by society and acceptance of the diverse workforce in the healthcare sector. Professions in the healthcare sector, in general, are declining in popularity. The decreasing number of applicants at nursing schools and an increasing number of nurses leaving the healthcare sector is an indicator of the healthcare sector losing its attractiveness as a labour market (Räisänen & Ylikännö 2021; Lehtokari & Manninen 2022). It is essential to boost social status and enhance the attractiveness of healthcare professions. Public opinion and perceptions of care professions are key factors in stimulating the potential healthcare workforce to enter the sector. As education and onboarding in healthcare are time-consuming and costly for the government, efforts should also be put into maintaining the workforce where social status and acceptance by society are strongly connected to work satisfaction and well-being. Creating respect for care professions requires a multi-faceted approach that involves education, professional development, fair compensation, recognition, and cultural change.

Additionally, immigrant women must overcome a barrier to acceptance from colleagues and patients. Finland has a somewhat short history of receiving immigrants. The number of immigrants is constantly growing. Thus, the acceptance of immigrant workers should naturally root in society as the proportion of immigrants grows in the population. However, encouraging diversity and inclusion in the workplace can also help to promote respect for immigrant care professions. Addressing bias and discrimination against immigrant care professionals is also essential for promoting respect in society. This can involve challenging negative stereotypes and attitudes and providing information and resources to help people recognise and overcome their biases.

7 Conclusions

In this study, the career trajectories of immigrant women in the healthcare sector have been examined using three theoretical frameworks: Transitional Labour Markets, Self-

efficacy, and Interpretative Phenomenological Analysis. Through the lens of these theories, valuable insights into the challenges and opportunities that immigrant women face in their careers in the healthcare sector have been gained.

The path of immigrant women into the healthcare sector in Finland is long, taking years of education, and employment is bringing new challenges. Despite long studies, immigrants are attracted to the healthcare sector by free quality education, guaranteed work, and work that has meaning and benefits society. The educational system and employment in healthcare function well in Finland, and the transition from education to the labour market is smooth. However, after entering the profession and being employed, immigrants experience difficulties and a decrease in motivation. The most frequently cited challenge for participants in this study was their integration into the workplace, which included language difficulties, discrimination, and mistrust from co-workers, supervisors, and patients. Even though all participants said that working in the healthcare system is a job with meaning, the lack of respect from society for the care professions in general, and especially for immigrants, is a huge demotivating factor.

A tremendous amount of effort has been put in at both individual and institutional levels in the training of healthcare workers. If trained professionals are not used to their full abilities, descaled, or decide to leave the healthcare sector, these efforts can be considered a huge waste. Therefore, work aimed at changing attitudes towards care workers, as well as immigrants working in the system, should have a positive effect on the attractiveness of the segment for new employees, as well as increase the motivation and satisfaction of those already employed by the sector. By creating more diverse, inclusive, and equitable workplaces, healthcare in Finland could rise to an exemplary level.

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Appendix 1

Information about the study

WHAT WILL HAPPEN

QUALITATIVE RESEARCH

In-depth interviews will be carried out. The interviews will be recorded, transcribed and analysed.

CONFIDENTIALITY

I will be the only person accessing the recordings and transcriptions. Your personal information will not be published. All data will be used anonymously in the study. After the thesis process comes to completion, all material will be stored securely for 5 years according to the EU GDPR regulations.

RIGHT TO REFUSE OR WITHDRAW

Participation is voluntary. You can choose not to partake in the interviews at any point without explanation. At that point all data will be deleted.

NEXT STEPS

Participant consent form will be filled and signed. You will receive an information form to make sure all preliminary data is accurate. Then, we will schedule the interview in a place comfortable to you.

ABOUT ME

Asiya Yakupova

Asiya.yakupova@metropolia.fi

ABOUT MY SUPERVISOR

Tricia Cleland Silva

Tricia.clelandsilva@metropolia.fi

THANK YOU

Appendix 2

Participant consent form

Participant Consent Form

PARTICIPANT CONSENT FORM

Title of the study: The Career Trajectories of Immigrant Women in the Finnish Healthcare
Location of the study: Metropolia University of Applied Sciences, Asiya Yakupova, asiya.yakupova@metropolia.fi.
Supervisor: Tricia Cleland Silva, Tricia.ClelandSilva@metropolia.fi

I ____________________ have been invited to participate in the above research study. The purpose of the research is to explore the career trajectories and experiences of immigrant women in the Finnish healthcare sector. The aim is to learn about the barriers and challenges immigrant women have had when finding their way into and within the Finnish healthcare system.

I have read and understood the written participant information sheet. The information sheet has provided me sufficient information about above study, the purpose and execution of the study, about my rights as well as about the benefits and risks involved in it. I have had the opportunity to ask questions about the study and have had these answered satisfactorily.

I have had sufficient information of the collection, processing and transfer/disclosure of my personal data during the study and the Privacy Notice has been available.

I have not been pressurized or persuaded into participation.

I have had enough time to consider my participation in the study.

I understand that my participation is entirely voluntary and that I am free to withdraw my consent at any time, without giving any reason. I am aware that if I withdraw from the study or withdraw my consent, any data collected from me before my withdrawal can be included as part of the research data.

By signing this form I confirm that I voluntarily consent to participate in this study.

If the legal basis of processing personal data within this study is a consent granted by the data subject, by signing I grant the consent for process my personal data. I have right to withdraw the consent regarding processing of personal data as described in the Privacy Notice.

Date

____
Signature of Participant

The original consent signed by the participant and a copy of the participant information sheet will be kept in the records of the researcher. Participant information sheet, privacy notice and a copy of the signed consent will be given to the participant.

Appendix 3

Information form

INFORMATION FORM

Please, kindly fill in the form below. In case you do not have information, or you do not want to answer the question, please, leave an - mark in the question box, hence researcher would be certain you have understood all questions.

1. *Name*	2. *Surname*
3. *Birth date*	4. *Birthplace*
5. *Mother tongue*	6. *Other languages*
7. *When did you move to Finland?*	8. *What was the reason of reallocation?*
9. *What education did you get in your home country?*	10. *Occupation in your home country*
11. *Did you study in Finland? If, yes, please kindly specify what.*	12. *Did you study in any other country?*
13. *Are you working now?*	14. *Please kindly specify the workplace and position.*
15. *Do you have a family in Finland?*	16. *Do you have children?*

I give my consent to the usage of the information given above for the researcher in her thesis study. No part of the information will be given to third parties. All data will be kept confidential and no names will be revealed in the thesis.

Name:________________________Signature:_____________________Date:____________

Appendix 4

Questionnaire guide

1. **Life before Finland**

- Where did you grow up?
- What was your life like before relocating to Finland?

If applicable:
- What is your educational background?
- What is your profession?
- Why have you chosen that field?
- Did you have a job?
- Was it difficult to find a job?
- Were you satisfied with your job?

2. **Relocation to Finland**

- Why did you move to Finland?
- What was it like to leave your home?
- What was your first impression of living in Finland?
- What were your expectations?
- How long do you live in Finland?

3. **Education in Finland**

- Have you studied in Finland?
- How challenging was the application process?
- Why have you chosen this/these particular field(s)?
- Did you have a part-time job during your studies?

4. **Recognition of the previous studies**

If applicable:
- Did you apply to previous studies' recognition?
- How did you find the process?

5. **Employment in Finland**

If studying, finishing studies, part-time job during studies or internship:
- How do you evaluate your job opportunities after graduation?
- How do feel about combining a job and studies?

If employed:
- How did you enter the labour market?
- What was your first job? Did you find it yourself or with somebody's help?
- Do you like your job?
- What are, in your opinion, the main reasons you have been chosen for this position?
- What are the main challenges in your current position?
- What are your opportunities at this place?
- Do you think it is more difficult for immigrants to get a job?
- Have you ever been discriminated at your workplace?
- What helped you to overcome challenges?
- Did you ever have moments of "hopelessness"?
- Was there anybody who helped and guided you through this/these moment(s)?

If looking for a new job:
- What job are you looking for?
- What is your strategy in the research process?
  i. Are you looking for vacancies yourself?
  ii. Did you ask for help from the Unemployment office?

   iii. Do you apply for a job somewhere else in the EU?
- Did COVID change your strategy?
- Do you think of changing your field?
- How could you describe your experience of the job search process?
   i. What kind of challenges (if any) in you encounter in healthcare?
   ii. What would you consider as your strengths and opportunities?

If unemployed:

- How long have you been unemployed?
- What are the main reasons for unemployment?
- How can you describe this experience? What are your feelings?
- What are your actions in the current situation?

6. Languages

- What languages do you speak?
- How did you learn Finnish?
- How important, in your opinion, to speak the local language - Finnish and/or Swedish?
- Do you think knowledge of the local language influence job search success?

7. Immigrant women

- What challenges (if any) in your opinion immigrant women encounter in Finnish healthcare?
- Would you consider the challenges manageable or irresistible?
- What would you consider as strengths and opportunities of immigrant women in the field of Finnish healthcare?
- Does your background bring you any benefits/challenges at your work?

8. Future

- Where do you see yourself in 5 years?
- Do you plan to stay in Finland?
- Are you optimistic about your future in Finland?

9. Family

- Do you have a family (in Finland)?
- Do you have a husband/significant other?
- How many children do you have and how old are they?
- Was it difficult to re-enter the labour market after maternity leave (if applicable)?
- Is your husband/significant other employed?
- Does your husband/significant other encourage you to enter the labour market?

Appendix 5

Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Study title: The Career Trajectories of Immigrant Women in the Finnish Healthcare

Invitation to participate in a research study

I'd like to invite You to take part in my research study, where I try to dig into the barriers and challenges immigrant women have had when finding their way into and within the Finnish healthcare system. I would like to explore every step of Your career path to understand what the challenges have been and what has helped You to achieve your goals.

You have been selected since You are or have been working in the Finnish healthcare sector. I plan to interview ten women. The interview will be conducted in an environment comfortable to You and will take around two hours of Your time.

This information sheet describes the study and Your role in it. Before You decide, it is important that You understand why the research is being done and what it would involve for You. Please take time to read this information, and discuss it with others if You wish. If there is anything that is not clear, or if You would like more information, please ask me.

Voluntary nature of participation

Participation in this study is entirely voluntary. You can withdraw from the study at any time without giving any reason and without there being any negative consequences. If You withdraw from the study or withdraw Your consent, any data collected from You, will not be used.

Purpose of the study

This study is an attempt to contribute to the knowledge of the career trajectories and experiences of immigrant women in the Finnish healthcare sector. Even though there is research showing the difficulties of immigrants in the healthcare sector, like language skills, onboarding, discrimination, and others, there is no knowledge of how the career paths of immigrant women develop in the healthcare sector.

Who is organising and funding the research?

This study is organised by me independently, and there is no organisation or individual funding the study. It is part of my final thesis at Metropolia University of Applied Sciences.

What will the participation involve?

If You agree to take part in this study, we will meet at a place of Your choosing. A one-time interview will take approximately two hours. I will be the only person interviewing You. Audio will be recorded in the interview, and only I will access the data. You will also be asked to fill in an information form and give your consent by signing the form.

The information form will be used to make sure that Your personal data is correct The audio recordings will be transcribed and used for data analysis interpretation. No names or any personal data will be revealed. The duration of the study will be around three months.

The method of research is semi-structured interviews. The sampling method will be a combination of both convenience sampling and snowball sampling. Convenience sampling means selecting people from my network. Snowball sampling means that You will be asked to recommend somebody from

Metropolia

Participant Information Sheet

Your network if You feel this person could contribute to the research and would be interested in participating.

Possible benefits of taking part

There will not be any direct benefits for You in this study. However, the findings could help other immigrant women to prepare and find their paths in the Finnish healthcare sector.

Possible disadvantages and risks of taking part

Some of the questions could make you feel uncomfortable or painful, but You have the right not to answer or elaborate on these questions.

Financial information

Participation in this study will involve no cost to You. You will receive no payment for Your participation.

No organisation or individual is funding this research.

Informing about the research results

The results will be available online at Theseus.fi. However, none of the participants will be identifiable from any report or publication. This study is the Master's Thesis of Asiya Yakupova.

Termination of the study

The researcher can terminate the study in case there will not be enough participants recruited.

Further information

Further information related to the study can be requested from Asiya Yakupova (researcher) or PhD Tricia Cleland Silva (supervisor of the study).

Contact details of the researchers

Researcher / Student
Name: Asiya Yakupova
Tel. number:
Email: asiya.yakupova@metropolia.fi

Person in charge of the study / Supervisor
Name: Tricia Cleland Silva
Helsinki Metropolia University of Applied Sciences / Senior Lecturer
Email: tricia.clelandsilva@metropolia.fi

Appendix to the Participant Information Sheet: A Privacy Notice for Scientific Research

Within this study, Your personal data will be processed according to the European Union General Data Protection Regulation (679/2016) and current national regulation. The processing of personal data will be described in the following items.

Data controller of the study

Metropolia

Participant Information Sheet

Data controller is the natural or legal person, public authority, agency or other body which, alone or jointly with others, determines the purposes and means of the processing of personal data.

Asiya Yakupova

Contact person for matters related to the processing of personal data
Name: Asiya Yakupova
Tel. number:
Email: asiya.yakupova@metropolia.fi

Types of personal data that will be collected
Name, Birth date, Birth place, Mother tongue, Other language skills, Year of moving to Finland, Reason for reallocation, Education in the home country, Occupation in the home country, Education in Finland, Education in other countries, Workplace and position in Finland, Marital status and children.

There is no statutory or contractual requirement to provide Your personal data, participation is entirely voluntary.

Personal data will not be collected from other sources
No personal data will be collected from any other sources.

Personal data protection principles
Audio recordings will be stored in Asiya Yakupova's personal computer in mp3 files. Transcriptions and personal information will be stored in Microsoft Word documents. The data will be stored in a password-protected directory under a specific user account to ensure only the researcher can access it.

For what purpose will personal data be processed?
This study is an attempt to contribute to the knowledge of the career trajectories and experiences of immigrant women in the Finnish healthcare sector.

Legal basis of processing personal data
The legal basis is consent granted by the data subject (You).

You have the right to withdraw the consent at any time as described in this Privacy Notice.

Nature and duration of the research (how long will the personal data be processed):

☒ One-time research ☐ Follow-up research

Duration of the research: 5 years.
= time frame needed for collecting and analyzing the data and for the publication of the study (plus three years for possible reclamations about the research results and time needed to respond to them).

What happens to the personal data after the research has ended?
Any research materials containing personal data will be destroyed.

Data transfer outside of the research registry:
No data will be transferred outside the researcher.

Possible transfer of personal data outside the EU or the EEA:
Your data will not be transferred outside of the EU or the EEA.

Your rights as a data subject
Because Your personal data will be used in this study, You will be registered to study registry. Your rights as a data subject are the following

- Right to obtain information on the processing of personal data
- Right of access
- Right to rectification
- Right to erasure (right to be forgotten)
- Right to withdraw the consent regarding processing of personal data
- Right to restriction of processing
- Notification obligation regarding rectification or erasure of personal data or restriction of processing
- Right to data portability
- The data subject can allow automated decision-making (including profiling) with his or her specific consent
- Right to notify the Data Protection Ombudsman if you suspect that an organization or individual is processing personal data in violation of data protection regulations.

If the purposes for which a controller processes personal data do not or do no longer require the identification of a data subject by the controller, the controller shall not be obliged to maintain, acquire or process additional information in order to identify the data subject for the sole purpose of complying with this Regulation. If the controller cannot identify the data subject, the rights of access, rectification, erasure, notification obligation and data portability shall not apply except if the data subject provides additional information enabling his or her identification.

You can exercise your rights by contacting the data controller of the study.

Personal data collected in this study will not be used for automated decision-making
In scientific research, the processing of personal data is never used in any decisions concerning the participants of the research.

Pseudonymisation and anonymisation
All information collected from you will be handled confidentially and according to the legislation. Individual participants will be given a code, and the data will be stored in a coded form in the research files. Results will be analysed and presented in a coded, aggregate form. Individuals can not be identified without a code key. A code key, which can be used to identify individual research participants and their responses, will be stored by Asiya Yakupova, and the data will not be given to people outside the research group. The final research results will be reported in aggregate form and it will be impossible to identify individual participants. Research registry will be stored in Asiya Yakupova's personal computer for 5 years, after which it will be destroyed by deleting all files and shredding the papers.