Universiteit Utrecht

Towards an intercultural future

An exploration of Muslim women's experiences in the Dutch geriatric care

Comparative Women's Studies in Culture and Politics
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Abstract

This study makes the working experience of ten Muslim women who are employed in the Dutch geriatric care sector available. It will do so by means of an intersectional analysis of existing statistics and research and a case study in two types of nursing homes for the elderly. Ten in-depth interviews will show how the working experience of these women is influenced by the intersection of gender, ethnicity and religion.

The Dutch healthcare sector is growing and changing. Research has shown that the healthcare sector as a whole has not adapted to the multicultural character of Dutch society. Language barriers and insufficient knowledge on cultural and religious practices that are non-Dutch are making the healthcare sector inaccessible for in particular immigrants of non-western descent. Government and social research organisations have stressed the need for the *interculturalization* of the Dutch healthcare sector. A first step would be to strife for intercultural employment policies: attracting personnel with different cultural backgrounds in order to share culture specific knowledge and experience.

Muslim women, with their particular knowledge of and experience with the Islamic faith and culture are considered a great potential to take on a leading position in this process of interculturalization. But they are very outnumbered in the healthcare sector as a whole, and the geriatric care in particular. This study focuses on the position of Muslim women in the geriatric care. The interviews show that these ten women have created a working life in which they use and share their personal perceptions of the Islam with their colleagues and clients.

This thesis proposes to use these women's personal narratives to develop new visions for an intercultural healthcare. Sandra Harding's perceptions of women's experience and her theory on *feminist standpoint epistemology* will be the red threat throughout this study and serve as a foundation for the personal stories of the women that were interviewed.

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I dedicate this thesis to my loving grandmother Henny, who was the proudest of them all.

Sophie Borgers
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Chapter 1- Introduction

1.1 The Dutch healthcare sector: growing and changing

In the Summer of 2000, the council for Public Health and Care (RVZ)[1] sent an advisory document to the Dutch parliament that was entitled 'Interculturalization of the Dutch healthcare sector'. The document was the result of an extended study on the accessibility of non-Western immigrants to the Dutch healthcare sector. This study showed that different generations of non-Western immigrants had not yet found their way into the Dutch healthcare sector. The invisibility of these groups of possible clients[2] was the most significant in the geriatric care sector (RVZ 2000, 6). This seemed to be caused by for example little knowledge of the provided care for the elderly and language barriers (RVZ 2000, 6). The RVZ also found a lack of *culture specific care* provided to these groups of immigrants. This for example in aspects of the care provided, such as food, attention to religious and cultural practices and the translation of medical procedures for clients and families.

The RVZ concluded that the Dutch healthcare sector needed to adapt to the growing multicultural society on a structural and sustainable basis (RVZ 2000, 59). The council stressed the need of the *interculturalization* of the provided care, the educational system and the employees. The process of interculturalization was described as follows:

> Policies and structural changes that focus on the creation of culture specific facilities in the Dutch healthcare that provide possible and existing clients (immigrants and non-immigrants) with equal quality of and equal access to the Dutch healthcare system. (RVZ, 2000, 12)

In the years after the study by the RVZ was published, the Dutch ministry of Public Health (VWS[3]) started several campaigns and studies to investigate the gap between the healthcare sector and the group of aging immigrants (Imansoeradi and Van der Meer 2009, 9). Hospitals and nursing homes were funded to attract more employees of non-Dutch descent in order to create more cultural diversity amongst the care providers. In the years following, several players in the Dutch healthcare sector concluded that the interculturalization had failed (Smulders and Rijkers 2011).

[1] Dutch Translation: Raad voor de Volksgezondheid en Zorg.
[2] Throughout this thesis, I will refer to persons that are in need of care as *clients*, because this term is officially accepted and used within the care sector and preferred over the term *patients.*
[3] Dutch Translation: Ministerie van Volksgezondheid, Welzijn en Sport.

Today, 14 years after this publication, the Dutch geriatric care seems more than ever ready for the process of interculturalization. The Dutch geriatric health sector is growing and changing. The expected ageing of both clients and personnel is asking for new ways of working and a more inclusive and diverse healthcare system. In the coming years, the first generations of non-Western immigrants will become an substantive group of the elderly in The Netherlands[4]. Their culture, religion and tradition ask for a different approach to existing protocols and also desires employees that are capable of providing the needed care. The Dutch healthcare sector is still very much based on Christian traditions and there is a need for new input based on Islamic traditions (Smulder and Rijkers 2011, 10). These developments are already resulting in the increase of *culture specific care*. This type of geriatric care provides a living environment for the elderly that is designed according to their particular culture, wishes and traditions. Knowledge on Islamic practices and ethical codes is a highly needed complement for the health sector as a whole, and the geriatric care in particular (Imansoeradi and Van der Meer 2009).

As the RvZ advised in 2000, the process of interculturalization of the healthcare sector should happen in every aspect of the system. Opportunities lie in the education and recruitment of personnel that holds culture specific knowledge that would make the geriatric care sector more accessible for non-Western immigrants in Dutch society (RVZ 2000, 6). It are these developments that hold great opportunities for research on the working experience of Muslim women employed in the Dutch geriatric care. Their knowledge on different aspects of Islamic religion and culture (as for instance language and religious traditions) is considered a valuable and future based potential for the culture specific healthcare sector (Imansoeradi and Van der Meer 2009, 9). Despite the multicultural character of the Dutch society and the labour market, previous research has shown that women with a Islamic background are still very outnumbered in the healthcare sector as a whole and the geriatric care in particular (Imansoeradi and Van der Meer 2009, 9).

This thesis analyses the position of Muslim women that are employed in the Dutch geriatric care sector: a minority in a mainly white, Dutch and Christian working environment. The working experiences of these women will be analysed by looking at the intersection of gender, religion and ethnicity. This study explores *how* Muslim women experience their

[4] Figures of the CBS show that in 2013, 4% of the people above 65 years of age is of non-Western descent. In the younger age groups, that percentage is higher. For example: 8% of the people between 50 and 60 is of non-Western descent. If this group will stay in The Netherlands, the percentage of non-Western immigrants above 65 will then increase in the next ten 5 to 10 years.

work: how is their well-being in the working environment? What are their motivations for choosing a career in the geriatric care? What are their struggles and opportunities? Ten in-depth interviews give insight in the different aspects of these women's working life and activities, such as contact with colleagues, education and well-being on the work floor. In a healthcare sector that is mainly still 'white' (Imansoeradi and Van der Meer 2009, 9), the position of Muslim women with a background that is non-Dutch is left unheard and unexplored.

This thesis has two main aims: first it will make the personal stories and experiences of Muslim women in the geriatric care available. A minority that is considered to hold great potential for future intercultural care, but is left unheard. Secondly, this thesis analyses the theory of feminist standpoint epistemology by Sandra Harding to use the working experience of these women for new visions towards intercultural healthcare.

1.1.1 Defining experience and using intersectionality

As introduced above, the personal narratives and experiences of the ten women I interviewed are the basis of this thesis. One of the aims of this study is also to use these women's experiences for further knowledge production. In order to understand how this can be possible, I want to reflect shortly on *what* experience is in this study and how the term will be used. Throughout this thesis, I will use the concept of women's experience as introduced by Sandra Harding in her theory of feminist standpoint epistemology (1991). Harding argues that it is women's experience that should be at the basis of feminist research in order to obtain new knowledge that is less partial and perverse (Harding 1991, 127). Harding states that experience is a complex concept that should be used wisely in feminist research.

Experience in Harding's theory is firstly about *what women do*: how they live their lives, how they shape their working career and their social relations. This is what she calls the 'dailiness of women's lives' that could be a preferable starting point for knowledge production (Harding 1991, 129). This dailiness is also very much applicable for the personal narratives of the women I interviewed for this study. I spoke with them about their working life, about their personal relation with their faith and how they see their future in the geriatric care. In this study particularly experience is about *doing* (working in the geriatric care) and also *being* (being a Muslim women in a white Christian society). But Harding makes a strong claim about experiences and personal narratives as a starting point for knowledge production, namely that they are always *situated* and thus never free of socially constructed influences. She writes:

But it cannot be that women's experience in themselves or the things women say provide reliable grounds for knowledge claims about nature and social relations. After all, experience itself is shaped by social relations (..) (Harding 1991, 123).

What important here in this claim about experience, is that Harding states that simply noting down women's personal narratives is not enough. 'What women say' cannot be the sole ground on which feminist research is based. Personal statements by women, says Harding, can be misleading, class-biased and even racist just as the personal thoughts of a researcher (Harding 1991, 123).

Furthermore, women's experiences change over time and should therefore never be claimed as a static source of knowledge. Experience are never static, never finished. They change throughout time and are influenced by public debate, working conditions and also the personal situation of the woman who speaks. This is the same for the women I have interviewed. The anti-Islam sound that is currently growing in The Netherlands and all over Europe, has its effects on for example the relation between the women and their clients. Several women had experienced Islamophobic reactions from clients they were treating. The current time set is thus 'shaping' the experiences of these women on a personal level.

In a response to her first work on standpoint epistemology, Harding also added an important aspect to her perceptions on women's experience by saying that there is not simply 'women's experience' as if women are all the same and thus share the same experiences (1993). She writes:

Feminist knowledge has started off from women's lives, but it has started off from many different women's lives; there is no typical or essential women's life from which feminisms start their thought. Moreover, these different women's lives are in important respects opposed to each other (Harding 1993, 65).

Harding here argues for a strategy to analyse women's experiences in a way that it provides insights in exactly *how* they are influenced by social constructions: taking on an intersectional approach. In her theory on intersectionality as an anti-racist strategy, Kimberle Crenshaw (1989) speaks of the importance of intersectional analyses when researching women's experience. Crenshaw claims that '(..) the entire framework that has been used as a basis for translating "women's experience" or "the Black experience" into concrete policy demands must be rethought and recast' (Crenshaw 1989, 40). Meaning that women's experiences that have been analysed according to a single-axis framework are biased and incomplete.

As introduced above, I am looking at how the working experience of the ten women I interviewed is influenced by the intersection of gender, ethnicity and religion. All three axes are very much intertwined in these women's working lives and they are very valuable to look at also for future changes in the healthcare sector as a whole (for example the demand of culture specific care). This study would be insufficient and incomplete had I solely looked at the aspect of gender that is affecting these women's working experience. Because these ten women are not 'just' female, they are women of a descent that is mainly non-Dutch and are employed in a mainly white healthcare sector. Their ethnicity, thus, is of importance as well. Furthermore, they are women with a upbringing and life that is influenced by Islam: they are Muslim women in a society that is based on Christianity. I need to analyse these three axes simultaneously and show how and where they intersect. I will use this intersection in both my analysis of existing research (chapter 3) and my analysis of the interviews (chapter 4).

Experience in this study is what Harding refers to as the dailiness of women's lives: it is their working experience, their personal lives and the way in which women design their lives in relation to men. By acknowledging that women's experience (just as men's) are shaped by social constructions and thus always situated, I can use the personal narratives of the ten women I interviewed as starting point for knowledge production. Intersectionality as a strategy will help me to analyse exactly how the stories of these women are situated.

1.2 Research question, subquestions and aims

As introduced above, this study explores the experiences of Muslim women working in the Dutch geriatric care sector and proposes to use these experience to develop new insights in and for an intercultural care model. The central research question of this thesis is therefore:

How do Muslim women experience working in the Dutch geriatric care and how does the intersection of gender, ethnicity and religion influence their working experience?

The research question captures the two main concepts that were shortly introduced above: women's experiences and the intersection of three axes of difference that are of influence on these experiences. The general research question will be mainly answered by my empirical research: namely the ten in-depth interviews that I conducted. In order to support the main research question with a theoretical framework, and to place the personal narratives of the women that I interviewed in a broader context, I designed two subquestions:

- *How is the intersection of gender, ethnicity and religion represented in current research on Muslim women working in the geriatric care?*

- *How can we use Muslim women's experiences to develop new visions on an intercultural healthcare model?*

To find answers to the first subquestion, I analysed existing research on Muslim women working in the geriatric care in the time period between 2000 and 2014. The aim of this subquestion is to gain insights in already existing facts, figures and theories about the position of these women in their work field. In the review of existing research I also take the intersection of gender, ethnicity and religion into account because it will enable me to see *where* and *how* the personal experiences and stories of the women I interviewed correspond (negatively and positively) with the outcomes of that existing research.

The second subquestion clearly states the general aim of this study: how to use Muslim women's working experiences for future visions on intercultural care. The exploration of this subquestion will serve as the theoretical basis for the general research question and this thesis. Central in the analysis of this subquestion will be Sandra Harding's theory on standpoint epistemology (Harding 1991 and 1993). I will use her view on the value of women's (working) experiences to give a theoretical ground to the stories of the women that I have interviewed.

1.3 Methodology

This thesis is based upon a qualitative research set up with in-depth interviewing as the main method. I have conducted ten *semi-structured interviews* guided by an interview guide that consisted of +/- 30 open-ended questions. The aim of the interviews was to gain insights in the actual working experiences of the ten women. In the interviews, I addressed several themes such as personal experience of Islam, medical procedures and the relation with colleagues. To make a comparison between two different working environments, I interviewed five women who are employed in a general nursing home *and* five women who are employed in a Islamic based nursing home.

As a complement to the in-depth interviews that were conducted, this thesis also contains a review of existing research on Muslim women in the Dutch geriatric care. This review will give insight in existing knowledge on the focus group and also how this research has been constructed. A further elaboration on methodology can be found in chapter 2.

1.4 Theory framework

In order to answer the main research question of this study, the data collected in the interviews is supported by a theoretical framework. Central to this framework is Sandra Harding's theory on feminist standpoint epistemology (1991). First I will look at Harding's understanding of *experience* and see what value the analysis of women's working experience can have for feminist research. I will also thoroughly analyse her concept of feminist standpoint to show how the perspective of the ten women I interviewed can complement existing research or serve as a foundation for further and extended research. The analysis of Harding's standpoint epistemology can be found in chapter 5.

1.5 Thesis outline

After this first preliminary chapter, this thesis consists of four more chapters and a conclusion. In chapter 2 I elaborate and reflect on the main method in this thesis: in-depth interviewing. Furthermore I will place these methods within the framework of feminist research and I will review my position as a research within this research project.

Chapter 3 is an analysis of existing research on the focus group (Muslim women employed in the Dutch geriatric care) and corresponds with the first subquestion of this thesis: *How is the intersection of gender, ethnicity and religion represented in current research on Muslim women working in the geriatric care?* The aim of this chapter is to review existing facts and figures on the theme and introduce main concepts that will be of importance for the analysis of my interviews, such as *intercultural care* and *ethnicity*.

Chapter 4 presents the results of the ten conducted interviews. In this data analysis I aim to answer my main research question, namely *how* do these ten women experience their work in the Dutch geriatric care? This chapter presents the everyday working experience of the ten women. The data are structured according to four themes: *being a Muslim woman*, *work*, *colleagues* and *clients*.

In chapter 5 will be a reflection on the collected data through Sandra Harding's theory on standpoint epistemology (1991). The aim of this chapter is to reflect on the second subquestion: *How can we use Muslim women's experiences to develop an alternative care model?* By analysing Harding's claims about concepts like *experience* and *standpoint*, I will demonstrate the value of the personal narratives of the women in this study.

Chapter 6 will be the concluding chapter of this thesis in which I reflect on the main research question and subquestions.

Chapter 2 - Methodology and approach

2.1 Presenting the main method: in-depth interviewing

The aim of this study is to gain new insights in the working experience and the position of Muslim women employed in the Dutch geriatric care sector. In order to gain these insights, this study is based on a qualitative research setup that is founded on the practice of in-depth interviewing. In this section I will elaborate on the choice for this method and explain how the practice of in-depth interviewing stands within the field of feminist research.

This thesis is based on *ten semi-structured in-depth interviews* with Muslim women employed in the Dutch geriatric care. The personal narratives of the ten women will serve as the foundation for this thesis. I have selected my participants in two groups of five women. The first group is employed in a non-culture specific nursing home for the elderly. This nursing home officially has no policies based on a specific culture, religion or focus group, but is standing close to the Dutch/Christian tradition. This is for example showed in the celebration of Dutch holidays such as Sinterklaas and Christmas.

The second group of women are employed in a culture specific nursing home with a focus on the Islamic culture and religion. This focus on the Islamic culture is concerning general policies, clients and personnel. The clients are mostly of Moroccan or Turkish decent and their needs and requests are the basis for the general policies of this nursing home. This selection of participants was done to make a comparison between two different working environments: one that is culture specific and one that is not. I analysed this comparison for example by exploring how the two different working environments are of influence on the well-being of these female employees on the work floor.

For the ten interviews, I used an interview guide[5] that consisted of +/- 30 open-ended questions. The interviews were semi-structured, meaning that I did have a clear interview guide with questions that I wanted to address, but that I also took the time to ask questions that were not in the interview guide if that was needed (Hesse-Biber in Hesse-Biber and Leavy 2007, 117). The conversations generally lasted 45 to 50 minutes, some even longer. I recorded all the conversations with a recording device, because it enabled me to make regular eye contact. I desired to let the conversations flow as naturally as possible. Meaning that I was prepared to step away from the interview guide when I thought that a theme that was not in that guide also needed some attention. Also, I was open for counter questions. For example, if

[5] The interview guide is included in this document on page 43.

the women desired, I would let them ask me questions about the aim of my study and my motivations for wanting to hear their stories.

I began each interview with noting down several biographical facts such as age, location, education and the history of their career. These are used in the profile of the interviews that I designed. As an introduction I spoke with the women about their personal relation with the Islamic faith, by asking questions like: *in what way was the Islam central in your upbringing?* and *what does your faith mean to you in your current life?* I believed this introduction to be important because it informed me about the meaning of Islam in these women's lives. It also made me aware of the many differences in religious practices and religious life amongst the ten women.

Next, I followed the interview guide and brought up the themes that I had chosen for the interview questions: *work, colleagues* and *clients.* I discussed general questions such as: *why does the geriatric care appeal to you?* and more specific questions such as: *how is working in a non-culture specific home different from the Islamic home that you work in now?* and *have you ever felt discriminated because of your faith in the workspace?*

All the interviews were conducted in the working space of the ten women. I made this decision for two reasons: first I wished to experience these working environments myself. This to see how and where these women worked, but also to experience the dynamics between employees, the clients and their family. This had the advantage that I could perceive actual differences in the two working environment as for instance differences in dress codes and interaction with clients. Secondly, I wanted to conduct the interviews at a place where the interviewees would feel comfortable. Inviting myself into their private lives at home would not have contributed to the interviews since the central theme was their *working* experience. Furthermore, I wanted to create a safe space so that the participants would feel comfortable sharing their experiences. I experienced that they felt comfortable being in a familiar environment and surrounded by people they interact with every day (their colleagues and clients).

Next to the data that I collected in the interviews, this thesis is also supported by a review of existing research on Muslim women working in the Dutch geriatric care. This enabled me to put the personal narratives of the women that I interviewed into perspective and also show in what ways their stories correspond, positively and negatively, with existing discourse. I also will show in what way this study problematizes certain conclusions or in what way it might complement existing research.

2.2 Why use qualitative research: opportunities and limitations

A qualitative research setup for this thesis enabled me to gain insights in *how* the ten women experienced their work in the geriatric care and *how* the intersection of gender, ethnicity and religion is of influence on the position of Muslim women in their working space. For this study, in depth-interviewing is the most suited and valuable research method to obtain insights regarding my central research question, because in an interview I could cover multiple themes more thoroughly. Asking the *how*-question has prevented me as a researcher from generalizing and simplifying the experiences of Muslim women employed in the geriatric care. Asking *what* and *how much* would not have given me the insights in the meaning these women give to their work, faith and personal lives.

This is exactly why, for this study, qualitative methods are preferred over quantitative methods. The aim of this study is to learn about women's experiences, about their everyday (working) life and their social environment. As I will show in my analysis, the women's working experiences were heavily influenced by their relations with colleagues, clients and their families. In-depth interviews have provided me with more information and insights in these factors than a structured survey could have done. Close-ended questions in a survey, such as *how much Muslim women work in the geriatric care?* or *what positions do they fulfil?*, could have provided me with patterns, numbers and even percentages. These outcomes will however not serve the central research question of this study because they touch upon *what* and *how much*, instead of *how* and *why*. In order to understand *how* Muslim women experience working in the Dutch geriatric care sector, I need qualitative data (women's stories) instead of quantitative data.

This exploration of the position of Muslim women in the geriatric care sector is about doing (practicing their profession) and being (being a religious woman). These aspects are so often central to feminist research as a whole. Feminist researchers choose to do qualitative research because '(..) most feminist views and perspectives are not simply ideas, or ideologies, but *rooted in the very real lives, struggles, and experiences of women* (Brooks and Hesse-Biber in Hesse-Biber and Leavy 2007, 3). Qualitative research enables feminist researchers to find patterns of difference amongst women (different struggles, different experiences) instead of patterns of same-ness that one could find in percentages and numbers. By exploring the intersection of gender, ethnicity and religion on the working experience of the women that I interviewed, I am exactly looking at patterns of difference. Firstly, I am looking at their position as an Islamic women of non-Dutch descent in a healthcare sector that is dominated by white, Dutch women (Imansoeradi and Van der Meer 2009, 9). Furthermore

this study has also taught me that my focus group, Muslim women, is far from homogeneous. Analysing patterns of difference amongst my group of participants is also necessary for this study because it again will prevent me from generalizing.

In order for this study to be inclusive and objective in a way that it covers the various aspects of difference (in the women's stories and my position as a researcher), I also wish to pay attention to the limitations that this qualitative research has. With a group of ten participants, the outcomes of the interviews can in no way be *representative* for the whole focus group (Muslim women employed in a nursing home for the elderly). An extended research period could have enabled me to do more interviews and make the comparison of the two working environments based on even more experiences. Being representative is thus not the aim of this study. The outcomes and conclusion are based on the *ten* conversations that were held and therefore they can provide new insights in for example the struggles and challenges that Muslim women in the Dutch geriatric care experience on a daily basis.

Although this study cannot be representative for the group of Muslim women working in the Dutch geriatric care, I argue that it is in many ways *indicative* and serves as a motivation for extended qualitative and quantitative research in the future. The data that was collected in this study provides new, in-depth information on how these Muslim women experience their work in a (culture specific) nursing home. As I will show in my review of existing research on the topic, previous studies have mainly focused on barriers for young girls with an Islamic background to choose a career in the Dutch healthcare (such as issues with intimate contacts with male clients and unfamiliarity with a profession in nursing). This study makes the working experience of women available who already work in the sector and have overcome these barriers. The ten women that I interviewed are all experienced in working with the elderly and use these experiences to form insights in culture specific care that can be of great value to those institutions (nursing homes, hospitals) who wish to develop that care model further in the future.

2.3 My position as a researcher

'Strong objectivity requires what we can think of as "strong reflexivity".' (Harding 1993, 69)

In a reaction on her earlier introduced theory on feminist standpoint epistemology (1991), Sandra Harding introduces the concept of 'strong objectivity' that should be at the core of feminist research (1993). Harding searches for methods to maximize objectivity within feminist (qualitative) research. She makes a strong claim about analysing women's lives and

experiences in order to gain 'empirically and theoretically preferable results' (Harding 1991, 119). But, says Harding, experience is always situated and thus never free of social and political values. She adds on her theory about women's experience by stating that the position of the research is of great importance when striving for 'strong objectivity'.

It is Harding's concept of reflexivity that is helpful to analyse my position as a researcher in this research process. A researcher should be reflective of her/his own position at all stages of the research process (Harding, 1993). For this particular study, the conducting of in-depth interviews asks for this 'strong reflexivity' on many levels. For example the designing of the interview questions and the acknowledgements of (hierarchical) differences between the interviewer and the interviewee need to be attended to. Reflexivity is a practice that keeps coming back in this process: choosing a theme for my research project, adapting in-depth interviewing as my research method and the way in which the thesis is written. Harding argues that all these stages are influenced by your own (socially constructed) believes and therefore a researcher should be fully aware of these believes (Harding 1993, 69). Believes here are for example presumptions or prejudices about your focus group, research methods and about your position as a researcher. I have realized that these beliefs are influenced by my own gender, ethnicity, age and class.

Therefore, reflexivity asks for looking inwards, looking at *who you are*. The same axes of difference that I use to analyse the stories of the ten women I interviewed, should be critically reflected on by me (Harding 1993, 69). This meaning age, descent, religion and even class. I am a young, white woman of Dutch descent. I was raised in a secular manner, meaning that no particular religion was central in my everyday life. I was raised by my mother and our family lived in what officially was named as below the poverty line. This looking inwards shows signs of why I became interested in studying (female) minorities. It also shows my privileges within Dutch society: being young, white and highly-educated. It shows in what ways I am different from the women I have interviewed.

This reflexivity raises the question whether a white, non-religious woman can do research on religious women that have original descent that is non-Dutch? Especially the aspect of religion was of importance for the interviews: how can a researcher that is not-religious and from a culture that is based on Christian traditions truly explore the religious and cultural identity of a Muslim woman? After conducting the interviews I started to problematize my identity as non-religious or secular, which is self-proclaimed. During the interviews I experienced that I was being identified by the interviewees as being religious (especially being non-Islamic). In the way that being Dutch meant that I was raised in a

Christian (and even Catholic, because I am from the south) culture and that I am in one way or another influenced by that. For example: most women expected that I respected the Sunday as a day of rest according to Christian traditions or that I even visited the church on Sunday. Even though I am a self-proclaimed secular woman, I am also Christian because I was raised in Dutch society. In his book *The multicultural Riddle: Rethinking National, Ethnic, and Religious Identities* (1999), Gerd Baumann argues that these perceptions of religion are influenced by the fact that people believe that religion has defined boundaries and therefore stands apart from for example cultural or political life. (Baumann 1999, 23). I therefore was under the impression that my raising in a Christian society was not influencing my position as a researcher. I find it very interesting to see that this process worked both ways during the interviews. Before starting the interviews, I had certain expectations about the religious identity of the women that I would interview. For example that some of them would wear a headscarf as a religious outing or that they would pray every day. The women also had their thoughts about me being a Dutch woman and therefore having affinity with Christian traditions and practices (which of course I do). I have experienced how identification as a religious woman is not only done by myself, but even more so by others.

Asking for strong objectivity (and therefore reflexivity) has also made me critically think about the comparison I had set up to make in this thesis. Namely that between a non-culture specific nursing home and a culture specific nursing home. I would argue that the Islamic home is an good example of a culture specific home because it provides medical care and a living environment that is based on ethical and practical traditions that are founded in Islam such as Halal food and segregated praying areas for men and women. The other home was a location that I had originally labelled as 'general' or 'non-culture specific'. But looking at this nursing home, being a part of the Dutch healthcare system that is generally based on Christian traditions and values, was that really true? Was this nursing home and its policies truly free of any cultural specific care?

I have come to state that it was not. The home had for example a catholic chapel for both clients and personnel and celebrated Christian holidays such as Sinterklaas and Christmas. When doing the interviews with the ten women, I learned that especially the women working in the Islamic nursing home referred to 'general nursing homes' as 'Dutch homes'. Meaning that they also considered those locations to be based on Dutch culture. Reflecting on this process, I would argue that this 'general' nursing home is indeed also culture specific. Since it is part of Dutch culture that is also still very dominant in the healthcare, it is not being labelled as being culture specific. In 2000, the RvZ already claimed

that there was too little awareness of the culturally defined healthcare system in the Netherlands (RvZ 2000, 42).

Next to understanding *who* your are, there should also be reflexivity or how that identity might influence the research process as a whole and the outcomes in particular. As Hesse-Biber states it: 'Reflexivity is the process through which a researcher recognizes, examines, and understands how his or her own social background and assumptions can intervene in the research process' (Hesse-Biber in Hesse-Biber 2007, 129). This reflexivity was clearly shown in the process of designing the interview guide. How to design truly open questions that are not based on biases and presumptions (as for instance presumptions on the religious identity of the women I interviewed)? I wish to illustrate this with an example: the presumption that the women employed in the Islamic nursing home were *more* religious than the women working in the general nursing home, influenced the first drafts of my interview guide. I noticed that the interview guide had little questions concerning the way in which the women were living their faith *privately* and *personally*. My interview guide therefore was to limited, because it assumed that their personal perceptions of the Islam were of little influence on how they practiced their faith in their working environment. The analysis of the interview data showed indeed that my assumption was wrong: the women working in the Dutch home stated to spend more time on religious practices such as praying, studying Quran and going to the Mosque than the women working in the Islamic nursing home.

Self-reflexivity has helped me to analyse my collected data in a more sufficient manner because it helped to truly and openly look at my data. Constantly I would ask myself the question: is this conclusion based on the conversations that I had, or is it influenced by my own perception or even the outcomes that I had hoped for before doing the interviews?

Chapter 3 – Contextualizing the debate

This chapter presents an overview of existing research on Muslim women working in the geriatric care sector. Instead of using Muslim women as a focus group (as I have done in this thesis), current research has been focusing on women of Turkish and Moroccan women in particular. The aspect of the Islamic religion is taken into account in these studies, based on the fact that the majority of Turkish and Moroccan women in Dutch society are Muslim (SCP 2012a).The aim of this review is to see how the position of women with an Islamic background in the Dutch healthcare sector has been explored over the time period between 2000 and 2014.

3.1 Discovering Muslim women's invisibility in the healthcare sector

The research that has been done on Turkish and Moroccan women in the Dutch healthcare sector, is mainly *qualitative* research with the practice of in-depth interviewing as the general research method. There seems to be very little quantitative research on the topic. An important reason for this is that since the abolishment of the 'Wet Samen[6]' in 2004, companies (including nursing homes and hospitals) are no longer obliged to register employees on the basis of their descent. The law was originally designed to stimulate cultural diversity amongst employees but was often labelled as insufficient and even racist (Buevink 2003). This makes it complicated to produce an overview of the current number of women of Turkish and Moroccan decent who are employed in the Dutch healthcare sector. The most recent numbers were collected in 2004 by the council for Labour and Income (RWI[7]) and show that only 0,5% of all female employees in the Dutch healthcare is of Moroccan descent, while this group of women make up 1,2% of the working population. For Turkish women this number is even lower: 0,4% compared to 1,7% (Bloemendaal et al. 2008, 40). The representation of Turkish and Moroccan women in the Dutch healthcare sector is thus very low.

The underrepresentation in the Dutch healthcare can be partly explained by looking at the participation of Turkish and Moroccan women on the Dutch labour market as a whole. In 2013, 40% of the Turkish women had a part-time or fulltime job. For Moroccan women that number lay around 37% (SCP 2012b, 145). In comparison to other women of non-Dutch descent on the Dutch labour market, such as Surinam women (60%) and women from the

[6] Short for: Stimulering Arbeidsdeelname Minderheden.
[7] Dutch translation: De Raad voor Werk en Inkomen (RWI).

Dutch Antilles (55%), the participation of Turkish and Moroccan women is lagging behind (SCP 2012b, 145). Research by the SCP showed that for these women in particular, changes in the personal lives such as marriage and motherhood are the main reasons to cut their working hours or even leave the labour market completely (SCP 2012b, 145).

Still, the number of Turkish and Moroccan women working in the healthcare is significantly lower than in other parts of the labour market. Existing research on this topic shows there are additional reasons for their underrepresentation, that lie in the combination of cultural and religious practices.

Researchers concluded that the underrepresentation of this particular group is already initiated in health education. Only 10% of all Turkish and Moroccan girls that are inscribed at vocational education[8] are studying for a degree in nursing and healthcare (Bloemendaal et al. 2008, 38). Amongst this group, a degree in the economic or administrative department is much more popular: 32% of the Turkish girls and 31% of the Moroccan girls are studying in that sector (Bloemendaal et al. 2008, 38). Their also seems to be a big gap between the required level that for example a function at a nursing home requires and the level of education that these women have followed (Imansoeradi and Van der meer 2009, 10). This meaning that the limited number of Turkish and Moroccan women that actually are in healthcare education complete their studies on a level that enables them to perform administrative and assisting functions, but leaves them unequipped for performing actual medical procedures (Bloemendaal et al. 2008, 6). For the geriatric care in particular this means that this group of girls and women are not educated to work in client-bound positions.

A study on the invisibility of Turkish and Moroccan women in the Dutch health care sector published in 2008 by the council of Labour an Income (RWI) concluded:

Turkish and Moroccan women are outnumbered in the healthcare sector because their participation on the labour market is still small. Furthermore, the vocational education in healthcare is less popular amongst these groups. In order to attract these groups to the healthcare sector, it is of great importance to investigate the causes of both developments (Bloemendaal et al. 2008, 6).

It is especially the second problem that researchers have been trying to explore: why are so little Turkish and Moroccan women choosing a career in the healthcare sector? Analysing this question is also important for this thesis. It enables me to show whether the ten women that I

[8] Dutch translation: MBO-opleiding

interviewed have experienced the same struggles or barriers during their time as a student (and as a nurse in their current position). Looking for patterns in the studies that have been executed, I found three factors that are possible barriers for these girls and women to start a career in the healthcare. Namely (1) the negative image that the healthcare has in especially Turkish and Moroccan culture, (2) the ethical struggle on intimate physical contact with male clients and (3) a lack of female role models.

Research shows that in particular the geriatric care sector has a negative image within Turkish and Moroccan communities. That image is based on the status that the geriatric care has in the land of origin. The profession of a nurse in a nursing home has a very low status (Imansoeradi and Van der Meer 2009). This seems to be caused by the unfamiliarity with bringing elderly family members to a nursing home. Within the Islamic culture, it is common to care for elderly family members such as (grand)parents at home (Imansoeradi and Van der Meer 2009, 27). The Dutch geriatric care system of nursing homes and domestic care for the elderly is therefore a quite unknown phenomena within these communities. The negative image of the Dutch geriatric care is based both on a limited knowledge of its possibilities, but also caused by a certain moral abjection of not caring for your own family members when they are older and needy. A respondent in the study '*Een tipje van de sluier: een studie naar de participatie van vrouwen met een Turkse en Marokkaanse achtergrond in de Amsterdamse gezondheidszorg'* published by SIGRA (2009) stated –

Your parents have taken care of you, so now you should do the same for them. A good Muslim must respect his parents and is responsible for their health and well-being (Imandsoeradi 2009, 29).

Other aspects that contribute to the negative image that the geriatric care has are for example the idea that the work is unhygienic and not financially sufficient (Imansoeradi 2009, 30). I would argue that this negative image has an effect on girls and women who are considering a career in the geriatric care. The profession that they are desiring (that of a nurse for example) is very low in status and the work that is included is considered to be 'dirty'. Furthermore, for the women themselves it might be a struggle to take care for the elderly in a nursing home when it is considered 'not done' to bring your own family members into such a facility.

Another important aspect of a career in healthcare that is considered as a barrier for Turkish and Moroccan girls, is the intimate contact with (male) clients and colleagues. This for example in practices such as the washing of a client or applying a catheter. Interviews with young girls and women showed that they struggle with the idea of performing medical

procedures because it is in conflict with their faith. The Quran prohibits women to have physical or individual contact with a man that is not related (and thus suited for marriage) (Imansoeradi and Van der Meer 2009, 21). Women also stated that performing night shifts with male colleagues is a situation that is not comfortable for them (Imansoeradi and Van der Meer 2009, 21). Performing medical procedures that are in conflict with prescriptions in Islam and working with male colleagues have proved to be barriers for these girls and women to start a career in the healthcare sector.

The limited number of Turkish and Moroccan women in the healthcare as a whole and the geriatric care in particular causes another barrier for young women desiring a career in these sectors. Participants in the studies that I analysed have stated that they experience a lack of female role models: women in their social environment (such as mothers, sisters and female friends) that are working in the geriatric care, and as a result of that are able to share knowledge and experience. They seek for role models in whom they trust and can look up too. These role models are considered to be of importance to stimulate younger girls to choose for a nursing profession because they can exactly take away certain worries or question (as for instance on intimate contact with male clients) (Bloemendaal et al. 2008).

I found that the underrepresentation of in particular girls and women of Turkish and Moroccan descent can be partly explained by their low participation on the Dutch labour market as a whole. Three general barriers, that are rooted in the Islamic faith and culture, are considered as other reasons to explain why this group is so outnumbered.

3.2 Gender, ethnicity and religion: analysing and problematizing

As analysed above, the current research on women of Turkish and Moroccan descent in the healthcare sector is very limited. A few studies are dedicated to the invisibility of these women in the healthcare, and the geriatric care in particular. In order to find answers to the subquestion that is central in this chapter (*how is the intersection of gender, ethnicity and religion represented in current research on Muslim women working in the geriatric care?)*, I will show how these axes of difference are used. Also, I will reflect on my study and in what way it might complement current research.

Existing research has focused on the distinctive position of women in the healthcare sector and I found that their gender is important in several conclusion that were made. First of all, the little participation of Turkish and Moroccan women on the Dutch labour market as a whole is caused by traditional stereotypes of the man as one to work fulltime and the woman to stay at home or work part-time. Research shows that the number of women who cut

working hours or stop working completely after marriage or having children is significantly high amongst Turkish and Moroccan women (SCP 2012b, 145).

I found that the aspect of gender is at stake in two of the three barriers that I have described above. In the physical and intimate contact with male clients, many girls and women find conflict with their religious believes. This experience is very gendered because the prohibition to have intimate contact with persons who are not related is exclusive to women. This means that this ethical struggle would not count for Muslim men working in the geriatric care. The modesty that is desired from their communities, and in particular from male relatives, is in this way complicating their possible choice for a career in healthcare.

Secondly, gender is at stake in the desire for more female role models. Women's significant experiences with for example the physical contact described above are very valuable for young girls and women who have doubts and questions about a career in the healthcare. These experiences can only be shared by women, because a Muslim man desiring a career in healthcare is not experiencing this particular (gendered) struggles.

When looking at the aspect of ethnicity, I found that in these studies it is mainly represented as descent: as land of origin. The focus on Turkish and Moroccan women in these studies is at first sight not problematic because the Turkish and Moroccan population in Dutch society represent the major part of all Muslims in Dutch society[9]. Therefore, exploring women of Turkish and Moroccan descent will also provide insights in the meaning of Islam in their lives. For this thesis, I have chosen a different approach because I would argue that by taking descent as a starting point and connecting religious identification to that descent, there is little attention to the differences in how religion is practiced by these women. Also, this thesis shows that Muslim women in Dutch society are of various descents, not just Turkish and Moroccan[10].

I would argue that I have tried to adapt a broader perception of the connection between ethnicity, descent and religion in this study. In his book '*The Multicultural Riddle: Rethinking National, Ethnic, and Religious Identities'* (1999), Gerd Baumann introduces a view on religious, cultural and ethnic identities that has helped me to explore how 'ethnicity' can mean more than descent only. He writes:

Finally, just as people emphasize different aspects of their language, body language, behaviour, and style in different situations, so too do they emphasize or abjure the attributes

[9] The SCP concluded that in 2012, 94% of the Turkish community in The Netherlands is Muslim. For Moroccan community this is 97% (SCP 2012a,

[10] This is shown in the profile of the interviewees on page 29.

of their ethnicity. (..) we therefore speak of "shifting identity" or "contextual ethnicity". Ethnic identities are thus nothing more than acts of ethnic identification that are frozen in time. (..) ethnicity is not an identity given by nature, but an identification created through social action (Baumann 1999, 20).

What Baumann is saying is that ethnicity is not a static, natural descent. It is a process of identification with for example the land of origin but also religious and cultural practices. Ethnicity in his view is situated and influenced by time, place and culture. For me, Baumann's understanding of ethnicity is were both descent, religion and culture come together. I choose not to select my participants on the basis of their descent (as is done in current research), because I think that in exploring women's religious identification (being a Muslim women), the notion of descent is already at play. Meaning that the society of origin of the women that I interviewed, already says something about the type of Islam that they are identifying with (for example Arabic Islam or African Islam). I hope this broader perspective towards ethnicity as a changing process that includes religion and culture, and not solely descent, has helped me to make this study different from (or a complement to) existing documents.

Chapter 4 – Working life: personal stories and experiences

This chapter presents the data that were collected from the ten in-depth interviews that were held for this study. I use this data to complement the research that has been done on Muslim women in the geriatric care, to show in what way the experiences of the ten women that I interviewed are underwriting the conclusions drawn from previous research. I will also show where that research is lacking and how the personal narratives of these ten women can be a motivation for new and further research. In particular I will show that taking into account religion (next to ethnicity and gender) as a part of these women's identity will provide a more inclusive view of these women's working experience.

In chapter 3, I stated that existing research is lacking the actual experiences of Muslim women who are already working in the geriatric care. Furthermore, by focusing solely on women of Moroccan and Turkish descent, I argue that the researchers have neglected other axes of difference that are of importance, in particular religion. The research that has been done focuses on the combination of gender and ethnicity (being a Turkish or Moroccan woman) as the reason of the invisibility of Muslim women in the Dutch healthcare. I argue that by taken religion into account as well we can learn more about the women's personal well-being in the work place and about the invisibility of these women in the sector. Baumann's definition of ethnicity as a non-static process of identification (with a nation, culture, religion) is a good starting point (Baumann 1999).

4.1 Profile of the interviewees

The ten women that I interviewed are all between the ages of 24 and 47 and have a minimal of 2 years of working experience in the Dutch geriatric care sector. All women work between 20 and 32 hours per week. Eight women finished their vocational education on the level of 'personal carer'[11]. This is also their function title in the nursing home that they work in. One woman is still finishing her mbo-3 degree to officially become 'personal carer', which means that she was not yet allowed to practice certain medical procedures before completing her degree. The last woman completed a higher vocational-degree[12] in nursing and has a function that is twofold: she is both team manager and 'personal carer'. Eight of the ten women have children, two of those eight are single-mothers. All participants live in the Netherlands.

Since the relation between religion and working experience is my focal point in this

[11] Dutch translation: mbo-diploma als zijnde 'verzorgende IG'. 'Verzorgdende IG' is the title for a nurse that provides intensive medical care on an individual level such as in a nursing home or a rehabilitation centre.
[12] Dutch translation: HBO-Verpleegkunde.

study, I explored the role that the Islam played in their lives. All women said that the Islamic religion and culture are central in their present everyday lives. Nine of the ten women said that Islam was also central in their upbringing. One woman was raised in a protestant environment, but converted to (Arabic) Islam when she was in her twenties.

Ethnicity is another axe of difference that is central in this study. For this profile, I use ethnicity in the sense of descent. Although the participants were not selected on the basis of their descent, I will take it into account, since it proved to be of importance in the way they practiced their faith[13]. Five women are of Turkish decent and two of Moroccan. The other three women originally came from Indonesia, Sierra-Leone and the Netherlands. An important condition for the interviewees was that they all stay anonymous in this study. Therefore, I will refer to the interviewees by means of fictive names.

4.2 Profile of the nursing homes

For this study I selected ten women coming from two different working environments. This with the intention to explore whether the working experiences of the ten women is influenced by the type of nursing home they work in (namely a Islamic nursing home and one that is based on Dutch traditions). What the work places have in common is that they are both nursing homes for the elderly that are in need of intensive and often 24-hour help. Both nursing homes have separate wings for elderly who are mentally ill (diagnosed with for example dementia) and clients that had physical disabilities (such paralysis after a stroke).

The Dutch-orientated nursing home offers place for 90 inhabitants and is located in the centre of a large city in the west of The Netherlands. The nursing home houses clients of many different cultures and descents and is therefore representative of the area[14] that it is located in. This nursing home officially has no specific focus on one certain culture, religion or focus group but it is strongly founded on Dutch, Christian values and practices.

The Islamic nursing home is located in a small village in the South of The Netherlands and offers place for 30 inhabitants. This nursing home is the only independent (meaning it has its own location and building) nursing home that is based on Islamic principles. Originally the home offered room only for clients of Moroccan and Turkish descent, but today the location is open for anyone who feels comfortable living in a home that is inspired by Islamic traditions. The clients who live in this nursing home come from all over The Netherlands

[13] This was for example shown in the differences between Arabic Islam and African Islam. The woman from Sierra-Leone stated that a headscarf in her culture had no relation to their vision of Islam. Fort the women from Turkey and Morocco the headscarf served as religious outing.

[14] The area is the multicultural heart of the city, meaning that there is a large population of different former immigrants living there.

because of the unique character of this location. The Islamic character of this home is at work in several aspects such as the service of Halal-food, different areas for praying and reading of the Quran and weekly visitations of an Imam.

4.3 Being a Muslim woman

In order to fully understand how religion (in relation to gender and ethnicity) are intersecting in the working lives of the ten women, it was important for me to know how they practiced their faith at work, at home, individually and with their families. I therefore asked questions about their upbringing, their religious practices at home and their perceptions of the Islamic faith in general.

Nine of the ten women said that the Islam has been part of their lives since they were born. They felt that their upbringing was heavily influenced by the Islamic faith and culture. Most of the women stated that as a child, they were educated to pray five times a day and instructed by their families to wear a headscarf as a teenage girl. They stated going to Quran-lessons and celebrating Ramadan. Ilja (31, Dutch nursing home) illustrated her commitment to Islam as follows –

I was born as a Muslim and raised that way. I find it important to do honour to that name. I have deep faith in Allah, he is my guidance. I live according to the Quran and I pray five times a day. When you are a Muslim, you should practice your faith every day.

Some of the women said that they would label their religious upbringing as 'strict'. Many of them have changed their lifestyles and designed new ways to practice their faith individually or with their families. Elissa (32, Islamic nursing home) told me -

I am still a Muslim, but I don't wear my headscarf anymore. Neither do I pray every day. My parents respect that, they have always let me make my own decisions about my faith. My sisters still wear their headscarves, but it doesn't make me a bad Muslim because I don't. Being a Muslim comes from within, not in the way you dress.

When discussing personal views of the Islam, it became clear that all ten women each had their very personal views on *how* the Islam should be practiced. Some of them expressed their faith by wearing a headscarf, other women said that they showed their commitment to Islam by living a modest lifestyle and learning their children about the Islam. I found that every woman had a clear view on how Islam fitted in their *current* lives. Just as Elissa, the majority

of the women that I interviewed said that their current lives asked for a different approach to their faith. In this, they stressed their role as a woman. Farah (36, Dutch nursing home) said –

A lot of girls are given a chance to go to school and have a job, even after they are married. That was not so evident for my generation. It also means that religion is not the only thing in our lives anymore, I am not as strict as my parents. I don't feel the need any more to wear a headscarf or pray five times a day.

This quote shows very clearly that most women were reconsidering the meaning of their faith in their lives. What became clear during the conversations about the women's personal perceptions of the Islam is that all ten women, both the ones who practiced their faith very strictly and the women who claimed to be less committed to the Islam such as Farah, said that they had a desire to be *more* connected and dedicated to the Islam, but in a different way than their parents or other relatives.

Several women said that their busy lives with work, children and a family to care for are demanding so much time and energy that it took away time to, for example, pray or to read the Quran. Others said that they felt that they weren't yet ready to commit more to religious practices such as Quran lessons or visiting the Mosque on a regular basis. Reasons that they gave for that hesitance to commit more time to their faith were for example their age and the fact that they did not have a family yet. The majority of the women stated to have great respect for people who were more devoted to Islam then, in their eyes, they personally were at that moment in their lives. Cem (40, Islamic nursing home) said to me -

I don't practice my faith every day, and I feel guilty about that. I have great respect for people who are very committed to their faith. I try to do the same, but often I just can't find the time. I try to always keep improving myself. My husband, for example, he prays more than me and he visits the Mosque more often than I do. He does not ask me to be more committed, but I want to do it mainly for my kids.

During these conversations about the personal experience of the Islam, I already noted how close their religious practices were connected to other factors in their lives such as work, family and their personal development as a person. For example when some of the women stated that they desired to be more dedicated to their faith, but stated that their busy lives with work and a family has restricted them in that desire. I would argue that their decision to pursue a career (in this case in the geriatric care) has motivated, and maybe even forced, to

rethink the way in which they practice their faith. Praying five times a day, for example, becomes a true challenge when handling work, children and personal time.

The interviews showed that all women have designed new ways to practice their faith that are suited for the current (working) lives that they are living. It also shows the different perception of the Islam and the way it is practiced (by for example praying, or wearing a headscarf). I found that the women still consider their faith to be of importance, but they have shaped it into their lives.

4.4 Work

Existing research on Muslim women working in the geriatric care has not so much focused on the actual working experiences of Muslim who are already employed in the sector, but rather focussed on possible barriers that prevented Muslim women and girls to choose a profession in the health sector (Bloemendaal et al. 2007, 5). As presented in chapter 3, the main barriers are the negative image that the healthcare sector has, ethical issues such as physical contact with (male) patients and the lack of female role models (Bloemendaal et al. 2007, 9). The actual *motivations* for young Muslim girls to choose such a career are being paid little attention to. I found it necessary to speak about their motivation to choose a profession in the geriatric care, because it might be an indication for the way in which the women that I interviewed had overcome the barriers that are so central in existing research.

The outcomes of the conversations confirm the three barriers that were concluded from existing studies. Nine of the ten women said that they had experienced negative or dismissive reactions on their choice for a profession in the healthcare sector[15]. These reactions were mainly coming from close relatives, both male and female, such as fathers, (grand)mothers and cousins. The women experienced these reactions mainly during their study, but some said they still have encounters in which they deal with surprising or dismissive reactions to their work. Several women said that their fathers were especially worried about aspects such as night shifts and working with male colleagues that are not relatives.

Another aspect that most women pointed out during the interviews and in existing research, is the image that working in the health sector has in their families and amongst other close relations. They stated that their work is often perceived as degrading and even dirty. Harima (28, Dutch nursing home) said -

[15] All women are educated to work in the many different sectors of the healthcare, so when choosing their education most of them did not yet make the decision for the geriatric care in particular.

A lot of people think that a woman should not work in the healthcare, because it is dirty. My female friends can't imagine that I will touch or wash a naked man. They feel that's dirty and unethical. But I believe God has given me this talent and that I am allowed to touch men in my profession. My clients need help, they can't take care of themselves anymore. That is very different from a private situation with a healthy man.

There are different aspects about this quote that I wish to discuss. First, there is the clear aspect of gender that is at stake here. Harima states that others perceive her work to be 'dirty', but she also stresses her position as a woman (she as a *woman* should not work in the healthcare). The women stated that this is caused by the Islamic commandment that they should not be in physical contact with men who are not related.

The quote of Harima also shows how most women that I interviewed motivate their work with the elderly *through* religion. I have experienced that all ten women make personal choices to justify their work and their interaction with male clients, like Harima. Some women also stated that the medical procedures that they are performing are strictly professional and therefore do not need to be shared with anyone outside of their working environment. All women said that they felt that caring for the elderly is an important pillar in the Islam. They had looked for justification for their work in their religion, and had found it there. Some women told me it was written in the Quran and others said that they had felt empowered by their personal relation to Allah. Ilja (31, Dutch nursing home) explained -

> My religion says that I can't see or touch a man's genitals other than my husband's. But at work, I often have to so I will do it. That's when I separate my personal believes from my professional attitude. That's what the Quran also tells me to do.

The interviews have shown that the relation between religion and the professional identity of these women is a very complex and intertwined one. As noted before, all women perceive their profession to connect to their faith in a positive way. They state that they are able to make a clear distinction between their professional attitude and their religious believes. But when asking them for examples, I learned making this distinction is complex for most women. Especially when speaking to the women who worked in the Islamic based nursing home, I found that the women appreciated a working environment that is considered of the intertwined relation between work and the personal perceptions of their faith. This is illustrated by Cem (40, Islamic nursing home) –

When I was working in a Dutch nursing home, I often had to serve pork or alcohol to my clients. I would do what they ask of me, but I did not feel comfortable. In this nursing home, I know that the clients will not ask this of me because they are Muslim too. This food is prohibited in the Islam, so I do not feel comfortable serving it and touching it.

As is illustrated in the quote, Cem told me that the Islamic character of the nursing home took away some of the ethical struggles that she was experiences when working in a general nursing home. This would mean that a culture specific working environment such as the Islamic nursing home can also be benefiting for the employees.

Discussing their work with the ten women showed me that they all were very passionate about their profession and had all found ways to bring their religious believes into their work, or chose not to do so. Some women stated that they were able to make a distinction between certain practices that are prohibited by their faith, but necessary in their work.

4.5 Colleagues

In this section, I will analyse the experiences of the participants in the relations that they have with their colleagues. As noted before, there is little existing research on the actual working experience of Muslim women in the geriatric care. The relation between colleagues is not adapted into those studies. I argue that this relation should also be researched, because the relation between colleagues is an important aspect of any working experience.

During the conversations, I learned that the women were very positive about the current relations that they had with their colleagues (both female and male). Important factors that they named were respect, tolerance and openness. None of the ten women said to desire of her male or female colleagues that they would also practice Islam or be Muslim. But during the interviews, the participants gave numerous examples from which I could conclude that an affection with, or at least the knowledge of the Islam was very much appreciated. For example, as Aisha (34, Islamic nursing home) said -

I feel comfortable that all my male colleagues are Muslim. This means I don't have to explain to him that for example during a team practice, I'd rather not perform certain intimate medical procedures on him. He understands that there is a difference between a dependent, ill client and a healthy male colleague.

Just as in the example of Cem in the previous section, some women state that they feel comfortable being around people at their working space that have the same thoughts about for

example social interaction and food.

When looking at the relation between the participants and their colleagues, there seems to be a significant difference between the Islamic nursing home and the Dutch nursing home. The women who work at the Islamic based nursing home say that their religion is a big factor in the relation with other colleagues (as illustrated above, this is for both female and male colleagues). Religion seems to be a factor in both professional and private conversations and encounters at the work place of the Islamic nursing home. For example team meetings and meetings with families of clients (professional) and lunch breaks or other 'free' moments (private).

The women working in the Dutch nursing home stated that their religion is something they wish to keep private. They said that religion was almost never a subject of conversation during work. I learned from the interviews that this difference between the two working environments can be explained by looking at the way in which the nursing homes are attentive to a certain religion or culture. The women in the Islamic nursing home say that, to them, it is obvious that the Islamic faith is central in every relation they have at their work, including the one with their colleagues. This because both clients and their families have specifically chosen for this type of nursing home and wish for the Islamic traditions to be central. Since the Islam is not part of the official character and policies of the Dutch home, it might be evident that the women working there stated that their religion is not central in professional meetings with their colleagues. Furthermore, all women working in the Dutch home said to have no need for more attention to religion in their relation with colleagues.

4.6 Clients

In order to gain insights in how the participants for this study experience their work, it is of value to investigate the relation that they have with the clients they care for. Again, I noted a difference between the culture specific nursing home and the Dutch nursing home. The women in the Islamic nursing home said that religion is an important aspect in their relation with their clients. This mainly because all the clients that live in that specific nursing home are first generation immigrants that grew up in Turkey and Morocco (SCP 2012c). The Dutch nursing home has very little clients with an Islamic background, and that is why the women who worked there stated that in their relation with their clients, religion is not very central.

All women (from the two working environments) said that they had no problems speaking about their religion with their clients if they desired that. An important condition for all women is that these conversations are not in conflict with their working schedule. None of

the women felt in any way restricted to speak about their religious believes with their clients.

It was only until discussing the relation between the participants and their clients that I encountered with examples of negative experiences in the work space. These experiences came from both previous working environments, as well as the current working places. Two of the ten women told me they had encountered with negative and discriminatory comments or felt treated in a negative way by their clients. Belén (27, Islamic nursing home) told me –

There were several clients at my previous working place that refused any help from me because I am Muslim. These clients had no problems with my Turkish colleague because she did not wear a headscarf, and I did. That hurts, but I won't let anyone put me down. I am a great nurse and a lot of the elderly who were hesitant at first came to appreciate me after a while because I took care of them just like anybody else.

Belén's quote illustrates very well that the negative encounters that some of the women I interviewed are based on an intersection of ethnicity and religion. Belén stated that people were often biased because of her headscarf. The other woman that had encountered with discrimination on the work floor said they also felt threated in a negative way because of their ethnicity (as descent) in the sense that they were labelled as non-Dutch or 'allochtoon'. None of the women stated that these negative encounters had made them question their profession. They stated to deal with these situations by having a strong believe in the nobility of their work and also their own capacities as a nurse.

The relation between the ten women and their clients proved to be a very diverse but appreciated relation. The women stated that they felt free to discuss religious themes if desired, but indicated that their religion is not very central in the relations with clients. A few women have experienced negatives reactions from clients that were directed at their religious outings or their descent.

Chapter 5 – Women's daily lives and labour: using standpoint epistemology

This chapter presents the theoretical exploration of how to use the personal stories and working experiences of the ten women central in this study for further knowledge production. In this chapter I analyse Harding's theory on a feminist standpoint and use her notion of the 'dailiness of women's lives' to reflect on the outcomes of my interviews presented in the previous chapter. Furthermore, I will put Harding's claim for using standpoint epistemology as a research strategy into action by using the working experiences of the ten women for a broader exploration of intercultural care.

5.1 Women's experience: standpoint epistemology

Sandra Harding developed her theory on a new philosophy of knowledge production in her book *Who's science? Who's knowledge* (1991). She claims that feminist researchers should insist on an 'objective location – women's lives - as the place from which feminist research should begin'(Harding 1991, 123). Harding's theory has been a great contribution to feminist researchers who already in the late 1970's started to develop alternative models of knowledge production in order to 'repair the historical trend of women's misrepresentation and exclusion from the dominant knowledge canons' (Brooks in Hesse-Biber and Leavy 2007, 56). Harding makes several strong claims about entering women's stories and standpoint into the natural and social sciences, that were traditionally dominated by men. She states:

> The distinctive features of women's situation in a gender-stratified society are being used as resources in the new feminist research. It is these distinctive resources, which are not used by conventional researchers, that enable feminism to produce empirically more accurate descriptions and theoretically richer explanations than does conventional research (Harding 1991, 119).

In general, Harding speaks of an exploration of women's lives and experiences as opposed to men's. She states that women's lives are distinctively different from men's in the sense that men and women use different patterns and practices to shape their lives (Harding 1991, 121). I would argue that these different patterns and practices are what is at the core of standpoint epistemology. Meaning that feminist researchers can explore (power)relations between men and women by looking at how they have designed their lives: for example their work, their education or their (possible) motherhood. In this way, Harding's theory is applicable for the

exploration of various power-relations in society: so not only women opposed to man, but also for analysing differences amongst women (as I have done in this study).

To truly understand Harding's claims for feminist research, I need to explore her concept of a 'feminist standpoint': the objective location that she states feminist research needs. Brooks (2007) writes:

Feminist standpoint epistemology is a unique philosophy of knowledge building that challenges us to (1) see and understand the world through the eyes and experiences of oppressed women and (2) apply the vision and knowledge of oppressed women to social activism and social change (Brooks in Hesse-Biber and Leavy 2007, 55).

In this definition, Brooks explains both the understanding of a feminist standpoint ánd the opportunities that Harding's epistemology offers. Brooks says that using women's standpoint is literally 'seeing through the eyes of oppressed women'. I would argue that the standpoint in Harding's theory is multi-layered. It is (as Brooks stated) literally a *perspective*, looking through one's eyes. But Harding is critical of this notion of a perspective because she says that the experiences feminist researcher collect by seeing through the eyes of women are always situated and influenced by social factors (Harding 1991, 123). Experiences change over time and they create different patterns in women's lives. In this sense, standpoint epistemology becomes a research strategy that enables (feminist) researches to explore the lives of different women in different times, societies and living environments (Harding 1993).

For this particular study, Harding's theory on experience, a feminist standpoint and knowledge building proves to be of great value. This because it enables me to understand *how* to use the personal narratives that I collected. In her notion of experience, Harding speaks of patterns that women (and men) have used to shape their lives (Harding 1991). She quotes historian Bettina Aptheker when discussing the possibility to start knowledge production from the 'dailiness of women's lives' (Harding 1991, 129). Aptheker states:

By the dailiness of women's lives I mean the patterns women create and the meanings women invent each day and over time as a result of their labors and in the context of their subordinated status to men. The point is not to describe every aspect of daily life or to represent a schedule of priorities in which some activities are more important or accorded more status than others. The point is to suggest a way of knowing from the meanings women give to their labors. The search for dailiness is a method of work that allows us to take the patterns women create and the meanings women invent and learn from them. If we map what

we learn, connecting one meaning or invention to another, we begin to lay out a different way of seeing reality. This way of seeing is what I refer to as women's standpoint. (Harding 1991, 129)

In her view on women's standpoint, Aptheker stresses the variability of women's experiences, patterns and meanings over time. I would argue that Apthekers argument, quoted by Harding, is in many ways applicable for this study. The central statement that she makes is 'a way of knowing from the meanings of women give to their labors.' For this particular study, 'labors' can be taken very literally, so looking at the meaning that the ten women I interviewed give to their *working life*. Aptheker suggests that feminist researchers should look at *how* women create their lives, which patterns do they create, use and share?

Looking at the personal narratives in this study, I have tried to search for these patterns. All ten women have created different patterns in their working lives that are valuable to research. They have provided insights in how these women operate in the Dutch healthcare sector that is mainly white and very much determined by Christian values and traditions. The interviews show for example differences in the way in which the women practice their faith at work: some women created space and time in their working environment to pray 5 times a day. Others decided to pray at home with their families or solely at the Mosque. All ten women have created different ways in which they can embed their religious believes in their work. This shows how their lives are different from for example non-religious women working in the geriatric care.

Continuing on Apthekers statement, Harding asks: 'Consider what we can learn about resistance to oppression and domination from Aptheker's account of the search for dailiness.' (Harding 1991, 129). So how are women opposing oppression in their everyday lives? I would argue that this resistance to oppression is alive in the stories of the ten women in this thesis. Almost all women stated that they had experienced negative reactions from close relatives towards their choice for a career in the healthcare sector. They resisted those negative reactions by choosing their own path and completing their degrees in nursing. Harding states that in this resistance (that is shaped by experience), feminist researchers should find knowledge. I have researched the motivations for these women to continue their career in the healthcare sector, despite the lack of support from their families. That has provided me with new information on their struggles (for example negative reactions on a headscarf), their well-being in the working environment and their desires (and open and tolerant relation with colleagues and clients).

5.2 Towards an intercultural future

The call for the interculturalization of the Dutch healthcare sector (by, for example, the RVZ in 2000) has resulted in the development of culture specific care. Culture specific care has taken on many forms over the years and resulted in for example an Islamic nursing home (that is central in this study), but also nursing homes for retired nuns and priests and living environments for homosexual elderly. The aim of this chapter is to use the experiences of the ten women in this thesis, to provide new insights in how culture specific care can be developed. I wish to discuss both the possibilities and dangers of culture specific care, based on these women's stories.

At the core of providing culture specific care is the ability of an employee to provide a client with a different ethnic or cultural background with adequate help and care (Actiz 2013, 9). All women in this study have experienced different situations in which they have cared for clients that were of a different cultural background than themselves. I argue that they therefore are all experienced with providing culture specific care, whether it is in the Islamic nursing home where Islamic traditions are central, or in the Dutch home that is based on Christian practices. The interviews show that culture specific care demands a flexible and tolerant working attitude. Meaning that they have to acknowledge a client's specific wishes or demands, even if they are in conflict with their own believes. This is for instance true for the woman who had to serve pork to a Dutch client and experienced personal struggles in doing so. Or for example for the woman who was discriminated by a client for wearing a headscarf. Both women explained that they had dealt with those situations by believing in the nobility of their work and their own capacities as a nurse.

Although this working attitude is demanding, all women in this study stated to experience this culture-sensitive attitude in their work as positive. They stated they felt comfortable being in a tolerant and open environment that is acknowledging different cultures, believes and practices. In this sense, I would argue that culture specific care can result in a working and living environment that is positive and comfortable for both employees and clients.

There are different situations where the cultural background of a patient is not the most important aspect of their needed care (Actiz 2013, 9). In the providing of culture specific care lies a danger of stereotyping the client and also the employee. I can illustrate both situations on the basis of the personal narratives of the ten women. One woman told me that she was guiding young students during their internship in the Islamic nursing home. She explained that whenever the student was a young Muslim girl, she (unconsciously) expected

that this girl would have ethical difficulties with washing a male clients or seeing him naked. She would therefore often keep the girl away from such encounters in their first weeks, instead she would let the student perform these practices on a female clients. She admitted that this was a prejudice and that many students stated to have no problem with washing male clients. The other way around happened as well: a woman told me that some clients in the Dutch home would sometimes ask for her headscarf. Knowing that she was a Muslim, many assumed that a headscarf was a obliged part of her religious outing. Knowledge on the cultural and religious desires of a client is an important aspect of providing culture specific care, but to avoid stereotyping, employees must be considered of differences amongst people.

Culture specific care is an important aspect of the interculturalization of the Dutch healthcare sector and the women that I interviewed all had their personal experience and view on this type of care. Exploring their experience in different types of nursing homes have shown both the advantages of culture specific care, namely creating an open and tolerant working environment with room for different cultural religious beliefs and practices. A danger lies in the possibility of stereotyping the client or the employee when there is too little attention to differences within a certain group of people.

Chapter 6 – Conclusion

In this study I have analysed the working experiences of ten Muslim women in the Dutch geriatric care. I have proposed to use these experiences for further knowledge building on, in particular, culture specific care.

My review of existing research shows that the research on especially Muslim women within the Dutch healthcare sector is very minimal. A small amount of studies have instead focused on women of Turkish and Moroccan descent and explored different barriers for these girls and women to choose for a career in healthcare. The invisibility of women of Turkish and Moroccan descent in the healthcare seems to be caused by three important findings. Firstly, the healthcare sector as a whole and the geriatric care in particular has a negative image in the Turkish and Moroccan community. Secondly, many girls experience struggles in the intimate contact with male clients and colleagues because it is in conflict with their faith. Finally, there seems to be a lack of female role models (such as sisters, mothers or aunts) in the direct social environment of the girls who are considering a career in healthcare.

The personal stories of the women in this study confirm all three barriers. All women have experienced negative reactions when pursuing a job in the geriatric care. Most of them said that important factors were the image that healthcare work has as to be ‘dirty’ and unethical because of physical contact with male clients. The women also confirmed the desire for more female role models with whom they might share knowledge and troubles that they are experiencing.

In this study, I did not want to focus so much on the barriers because I believe that using the experiences of Muslim women who have successfully pursued a career in the geriatric care might provide more insights. Researching the ‘success stories’ shows how these women have overcome their barriers and have given meaning to their work (Imansoeradi 2009, 11). It are actually these women that are the so much desired role models for the younger generation.

The interviews have shown that the women in this study have a strong believe in the work they perform every day. They experience loving and pleasurable moments in the relations with their clients and colleagues. All women have stated to desire an open and tolerant working environment in which different cultures and religions are respected. They ask this both from their clients and their colleagues. For some women in this study, their religious believes are in conflict with aspects of their work. This for example in being alone

with a male colleague, serving alcohol and non-halal food or performing medical procedures such as placing a catheter on a male client. When performing these daily practices at work, the women in this study state that they make a distinction between their religious beliefs and their professional attitude. None of the women stated that these struggles have made them question their future in the geriatric care, but they feel comfortable if there is understanding and respect for their position. Most of the women stated that they felt comfortable having colleagues that are also Muslim, because they could relate to them in a better way than non-religious women.

I have explored Sandra Harding's theory on feminist standpoint epistemology in order to investigate the value of the personal narratives of the ten women for feminist research. I found that especially her notion of the dailiness of women's lives has been very applicable for this study. I have argued that by looking at the meaning these women give to their work, in relation to their religion and culture, we can learn about the struggles they experience in the Dutch geriatric care. I showed that their knowledge and years of experience are a welcome contribution to the debate on culture specific care. Their personal narratives have shown the possibilities of culture specific care: namely creating an open en and tolerant working and living environment that is representative of the Dutch multicultural society. Extended research on culture specific care could provide solutions for the dangers of his strategy such as stereotyping both employee and client, and the danger of creating segregated working and living environments.

This study is a modest contribution to the exploration of Muslim women's experience in the geriatric care. I hope that this thesis might be a motivation for extended research. Research that is considerate of the meaning of the Islamic religion and culture on the lives of these women (in combination with their gender and ethnicity), can provide new and more inclusive information on both their position in the geriatric care and their possible contribution to a healthcare system that can adapt to the Dutch multicultural society.

Appendix A: Consent form

Geachte mevrouw,

U bent gevraagd om deel te nemen aan een onderzoek naar de werkbeleving van vrouwen met een islamitische achtergrond die werkzaam zijn in een verpleeghuis voor ouderen. Dit onderzoek wordt uitgevoerd door Sophie Borgers in het kader van de Masteropleiding Genderstudies aan de Universiteit Utrecht. Het doel van dit onderzoek is inzicht te krijgen in de positie en werkbeleving van vrouwen met een islamitische identiteit in de zorg. Centraal staat de vraag op welke manier het geloof een rol speelt in het werk en de relatie met bewoners.

Voor dit onderzoek zal u individueel worden geïnterviewd. Het interview zal tussen de 30-40 minuten duren en wordt afgenomen op een met u overlegd moment. Het interview zal worden opgenomen met een recorder, zodat de inhoud van het gesprek op een zorgvuldige manier kan worden genoteerd en uitgewerkt. De opnamen van deze recorder blijven te allen tijde in het bezit van de onderzoeker (Sophie Borgers). In de publicatie van het onderzoek zullen namen en locaties niet worden gebruikt of openbaar worden gemaakt.

Deelname aan dit onderzoek is vrijwillig. Vragen of problemen met deelname aan de interviews kunt u altijd bij mij melden. U kunt zich altijd terugtrekken uit het onderzoek. Als u benieuwd bent naar de resultaten van het onderzoek, kunt u ook bij mij terecht. U kunt contact opnemen met mij via sophieborgers@gmail.com

Sophie Borgers
Universiteit Utrecht

Ik heb dit formulier gelezen en stem er mee in,

…….. ……..

Datum Handtekening participant

…….

Handtekening onderzoeker

Appendix B: Interview guide

1. Introductie
Algemeen beeld van de respondent, gegevens blijven anoniem. Schriftelijk ingevuld voorafgaand aan het interview

Naam, leeftijd, woonplaats, gezinssituatie

Opleiding
- Gerelateerd aan de zorgsector?

Hoe lang al in dienst bij deze zorglocatie?
- Eerdere werkervaring in de zorg?

2. Geloof en werk
Algemeen beeld van de huidige functie en de werkzaamheden in relatie tot de religieuze identiteit

Motivatie om te werken in de (ouderen)zorg?

Heb je bewust gekozen voor een functie in een islamitisch/algemeen verpleeghuis?
- Kun je die keuze toelichten?

Zijn er personen uit je direct omgeving van invloed geweest op de keuze voor een islamitisch/algemeen verpleeghuis?
- Zo ja: wie en op welke manier?

Welke voorwaarden speelden een rol toen je koos voor deze functie?
- Zijn er voorwaarden geweest die een verband hadden met je geloof?

Welke rol speelt je geloof in je dagelijkse werkzaamheden in deze functie?
- Kun je voorbeelden geven van verrichtingen waarbij je geloof een belangrijke rol speelt?

Op welke manier komen religieuze uitingen of overtuigingen terug in je dagelijkse werk?

Heb je het gevoel dat je deze uitingen voldoende kunt uiten tijdens je werk?
- Waarom wel/niet?

Zijn er momenten waarop je het gevoel hebt dat je je niet goed kunt uiten?
- Zo ja: heb je daar voorbeelden van?

Spelen er bepaalde ethische kwesties die relatie hebben tot je geloof mee in je dagelijkse

werkzaamheden?

- Kun je daar voorbeelden van geven?

3. Geloof en collega's

Collegialiteit en sfeer op de werkvloer

Op welke manier speelt de beleving van je geloof een rol in het contact met je collega's?

- Kun je daar voorbeelden van geven?

Ben je open naar je collega's over je geloof?

- Waarom wel/niet?

Vind je het prettig als je collega's dezelfde overtuigingen hebben als jij?

- Waarom wel/niet?

Is je overtuiging van invloed op de band die je met je collega's hebt?

- Zo ja: op welke manier?

Heb je ooit te maken gehad met negatieve ervaringen met je collega's die verband hielden met je geloof?

- Zo ja: kun je daar een voorbeeld van geven?

4. Geloof en cliënten

Omgang met cliënten en ethische kwesties

Op welke manier komt je geloof naar voren in de relatie met je cliënten?

Vind je het belangrijk dat je cliënten weet hebben van je religieuze identiteit?

- Waarom wel/niet?

Vind je het prettig/onprettig dat je cliënten dezelfde binding hebben met het geloof dan jij?

- Op welke manier?

Merk je dat cliënten behoefte hebben aan een gelijke binding met het geloof?

Heb je ooit een negatieve ervaring gehad in relatie tot je geloof en cliënten?

- Zo ja: wil je daar iets meer over vertellen?

5. Beleid

Beleid gericht op werknemers, gericht op culturele diversiteit en vrijheid van religie

Ben je op de hoogte van (eventueel) beleid dat er binnen de zorglocatie bestaat dat verband houdt met je religieuze identiteit?

- Zo ja: kun je vertellen waar dat beleid uit bestaat?

Wordt er met werknemers gesproken over zaken als het uiten van een religieuze identiteit of andere culturele waarden?

- Zo ja: wat vind je van die communicatie?

Heb je het gevoel dat je in je functie een bijdrage levert aan de introductie van eventueel nieuw beleid?

Heb je het gevoel dat je als vrouwelijke werkneemster met een islamitische achtergrond open kunt zijn over je identiteit, bijvoorbeeld in relatie tot je meerderen?

Zijn er zaken in het huidige beleid gericht op religieuze en culturele uitingen van het personeel die je verbeterd of veranderd zou willen zien?

- Zo ja: welke?

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