

Health Care for the Day Shift



LUND UNIVERSITY

Taking Health Care to the Day Shift

A Pilot for a New Health Care Service in Neighborhood Pubs

Taneli Heinonen

Master of Applied Cultural Analysis

Department of Arts and Cultural Sciences

TKAM01 - Spring 2012

Supervisor

Orvar Löfgren

Abstract

This thesis is based on an ethnographic research on the role of health and public health care in neighborhood pubs in Helsinki. The goal was to understand why potential customers of the public health care services do not utilize the services offered. Based on the new understanding generated, a pilot health care service was developed in cooperation with two pubs, municipal health care, and the nursing students of Metropolia Applied University. The service took the form of a health visit, in which the nursing students entered the pubs in pairs to offer a possibility for metering blood pressure and blood sugar - as well as a chance to discuss any health-related issues. The pilot of these visits took place in two pubs in Helsinki in 2011. The ethnographic research for this thesis was carried out in these two pubs over the course of the pilot project. The research suggests that the social capital of the pubs can be applied in bridging the gap between the masculine cultural forms prevalent in the pubs and the social world of the public health care. Investigating the challenges facing the Scandinavian public health care system, as well as the historical trajectory of masculinity in the Finnish neighborhood pubs form the background for analyzing the health visit. The entire thesis is framed within the larger context of initiatives aimed at leveling socio-economic health inequalities.

Keywords: public health care; health inequalities; ethnography; pubs; masculinities; social capital; body; health visit

Acknowledgments

This project involved multiple actors and I'm extremely thankful for having a possibility to be part of such an interesting and innovative project. Healthy Neighborhood program and the Health Center of Helsinki gave the platform for the program and the students of the Metropolia Applied University carried out the actual health care work. My colleagues at Gemic carried out the first phase of the field research. People at the pubs were open and interested in the idea and their positive attitude and input was what made the pilot possible and successful. I wish to give special thanks for the owner and staff of the pubs who made the pilot possible. For helping me out in my mere contribution, I wish to thank my supervisor Orvar Löfgren, my colleagues Johannes Suikkanen, Sakari Tamminen and Otto Utti, my fellow students and teachers in the MACA-program and everyone else whom I had the chance to discuss the project with.

Helsinki, 2013-04-03

Taneli Heinonen

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1. Introduction

Scandinavian welfare societies organize public health care for their residents to promote the health and wellbeing of the people. Health care systems work on a similar principle in all Scandinavian countries, but in this project the focus is on Finland and especially on the challenge of leveling health inequalities between different socio-economic groups. Health inequalities are a large-scale national challenge, a social problem, and an economic problem. Public policies often aim to answer these kind of large-scale macro-problems by targeting the population as a whole through laws and regulations.

Health inequalities are a result of complex entanglements of policies, social dynamics and trajectories that play a role in peoples lives. In order to address the complexity of health inequalities we need to understand multiple challenges that take place in particular contexts, in particular ways, among different groups of people. This research project focuses on one specific aspect of health inequalities: how can public health care reach out to people who, for some reason, tend to avoid the health care system or are suspicious of it? An ethnographic approach is applied in understanding the health issues in one specific setting, in which people come and spend time in. Analysis is then applied in designing a new health service that would contribute to the leveling of health inequalities through this specific setting.

This thesis is about a pilot project in which neighborhood pubs were utilized as places through which health care institutions could reach middle-aged men with high health risks by understanding their everyday lives and providing service that could serve as a route to a healthier life and a better relation to public health care. The project was part of a 4-year innovation program the Healthy Neighborhood-program, and ran by the municipal health care of Helsinki.

I begin the thesis by discussing the challenge of leveling health inequalities. I then introduce the health visit pilot and discuss the aim of the thesis. In the second chapter I reflect on the application of the methodological tools of cultural analysis to the problems at hand. In the third chapter I discuss the challenges of the public health care system in Finland and analyze the role of the health visit pilot in relation to them. In the fourth chapter I describe the historical trajectory and the current social

world of the neighborhood pubs in Finland. The fifth chapter is about bringing public health care in to the space of the pub. I describe and analyze the actual health visit events that took place in the pubs. In the sixth chapter I summarize the insights learned over the course of the project and discuss possible future traits in applying this kind of approach to the leveling of health inequalities.

1.1 Leveling of Health Inequalities in the Universal Welfare State

According to the Finnish constitution everyone is entitled to essential living and care, even if they themselves would not be able to acquire the safety that is essential for the dignity of human life. Based on the guarantee of human dignity, the state is considered to be responsible for promoting the health and well being of the citizens. This responsibility is carried out in practice by the municipalities organizing health care for all of their residents (STM, The Ministry of Social Affairs and Health, 2012). [Double check the citation format for APA, you have a period that's not needed at the end of the sentence, and the period inside the citation parentheses should actually be outside. I fixed it on this one and some of the next paragraphs, but all other citations need to be fixed like this.] Inclusion of everyone in the sphere of health care services has been one of the great success stories of the Scandinavian welfare states, as the health and wellbeing of the population has improved over the course of time.

However, inequalities within the population have grown over the past few decades in Finland. Typical national diseases such as cardiovascular diseases or type 2 diabetes are often contemplated by the authorities by comparing the occurrence level between the most educated and highest income fifth and the lowest income fifth of the residents. Health risks are considered to be social, not biological of nature. If it is possible for a certain group to achieve a level of health it is considered also possible for others to achieve. (Rotko, Aho, Mustonen & Linnanmäki, 2011.).

Besides the income and education level, gender is a factor that seems to affect the level of health. Life seems to be especially risky for men, who are middle-aged and of lower income groups. Unemployed, early retired, and temporary shift workers are the ones who mostly make up this socio-economic group. The life expectancy for a male in the lowest income fifth, for example, is 12,5 years shorter than for a male of the highest income fifth.

Authorities have strived for leveling the socio-economic health inequalities through extensive policies and planning. Despite the political will, it has been difficult to take these ideas to the concrete level and actually succeed in markedly improving the health and wellbeing of the groups

that suffer the most from health problems. (Rotko et al., 2011.) Outside the sphere of legislation the traditional efforts to promote health in Finland have been through educating citizens by information campaigns on healthy lifestyles and warning about unhealthy choices. Given that Finns are one of the most highly educated nations, this lack of success implies that there is more to health behavior than the mere knowledge required to make rational decisions.

People who suffer from health problems are seen as a group that should be helped and supported through public actions (Rotko et al., p. 18-20). Basic primary health care services are considered important in tackling the typical nationwide health problems. One aspect of the problem of health inequalities is that even though these primary health care services are available for everyone they are not being utilized to the same extent by everyone. We have a large amount of people, especially men, who end up having problems with their health and do not seek help until it is late, or even too late. (See for example Kotro & Sepponen, 2007).

In this thesis, I try to open up the reasons behind these issues while considering how public health care institutions could help level inequalities by approaching and serving people who are currently not taking advantage of available public health services. The aim of this research is to understand the problem from the perspective of one specific place through which some of the people with health problems could be reached – the neighborhood pub. The main target were the middle-aged men who are in the greatest risk of typical lifestyle-related health problems in Finland.

1.2 Understanding of the Potential Customer as a Tool in Creating Effective Services

Citizens as the users of the public services have become referred to as customers over the past few decades. The relationship between a customer and a service provider implies something else than the traditional relationship between the public institution and a citizen. In some discussions this shift has been seen as a part of the rise of neoliberalist governmentality in new public management, or the expansion of the market based logic into the realm of public services. (See for example Rose & Miller, 2008 and Koivusalo, Ollila & Alanko, 2009 & Eräsaari, 2007 in Finnish context.) The illusion of a voluntary contract of partnership between the individual as a customer who makes choices when acquiring services from the public sector hides the actual power relation and may result in a logic in which individual gains responsibility rather than freedom. The customer may end up becoming the one who needs to know what is good for her, or she might become a paying customer

like any customer of private market services. (See for example Sulkuinen, 2007)

On the other hand, discourse of serving the customers implies the aim that most good businesses do have, serving their customers as well as possible in order to have them come back and choose the same service provider again and again. Companies follow the competition in the markets, conduct research, and develop their services in order to meet the needs and desires of their customers as well as possible. Serving the customer is at the heart of this kind of development. Could customer-centric approaches to business development then have something to give in the development of the public services? Or is it inevitable that the discourse of the users of public services as customers has to lead towards everyone being responsible of themselves as individuals who either take care of themselves or have to pay others to take care of them? This research will not give a concrete answer to this question, but it may serve as food for thought and an example case in which one type of customer-centric approach to the development of services is taken in the field of public health care.

As a starting point, we are never just citizens, customers, nor users of services. We are rather poly-users of all kinds of services and products. We are people, living our lives among others; we are never just individuals, but always entangled in our relationships, within families, groups of friends, co-workers and acquaintances. To understand people as customers, we need to understand the social activities they engage in. Services take place in this context, which is the everyday life of the customers. That is the context in which the service has to be meaningful and provide value for the customer. (Ruckenstein, Suikkanen & Tamminen, 2011) What, then, is the gap between public health care services and the everyday lives of potential customers who don't currently utilize the services? To understand and bridge the gap between the public health care services and their potential customers we need to study their everyday life and the role of health and health care in it.

1.3 Scope of the Study, Aim and research questions

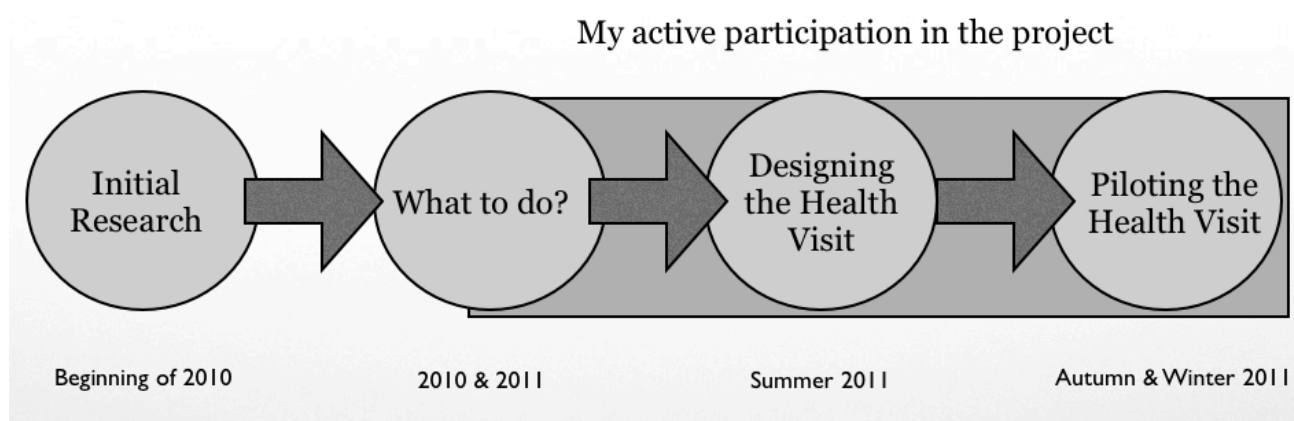
The starting point of this project was to take seriously the possibilities of customer-centric service development in the context of efforts to reduce health inequalities. The research process began by weighting who are the different groups of people currently not reached by the public health care and why are they not being reached. Then it was discussed and considered where and how these people could be found and best understood. Statistics point out that people currently being most passive in the use of health care services and suffering from health problems are middle aged men. (See for example Klavus, 2010 p. 34) Bars and pubs were considered as potential places to find this group of people, which turned out to be correct. As a part of the Healthy Neighborhood program, Gemic, a

consultancy specialized in ethnographic research, conducted a study in the pubs, bars and restaurants of Eastern Helsinki during the conventional working hours of the day shift (9-17). Study of the day shift in the pubs served as a starting point in the process that later on produced the health visit pilot and a guidebook for organizing a health visit based on the lessons learned during the pilot.

In the second phase, as I joined the project, the goal was to put the findings of the first phase of research into action. With the understanding gained from field research on how men in the pubs view health, health care, and their relation to it, we went back to the pubs and discussed possible ideas for health promotion projects with the customers and staff of the pubs. We had to find ways to promote health that would be meaningful for all the people in the pubs: customers, bartenders, and owners. On the other hand, it also had to be coordinated with the professionals from public health care, so that the interests of all sides would be pieced together.

As a result of the further research, discussions, and planning, two voluntary pubs were chosen for a pilot project in which we, together with their staff and a group of nursing students, tried out a health visit service in the pubs. For a few months' time in the end of 2011, every other Tuesday from 1pm to 3pm two health care students entered two restaurants in the Living Lab area to offer a chance for measurements of blood pressure and blood sugar and a possibility for open discussions over any health issues one might be interested of. Five visits took place in the first pub and four in the other. During the visits I conducted participant observations at the pubs. After each visit I had a group discussion with the students, and in some cases, their teacher. Based on these experiences a manual for organizing a health visit in a pub was produced at Gemic.

FIGURE 1. Timeframe of the project and my active participation.



In this thesis my aim is to examine this whole process and the social context of the gap between public health care services and the everyday life at the pubs. Through this examination my aim is to find answers to the question of how it might be possible, by taking services into pubs, to make health care services relevant for people who otherwise are not willing to use them. What happens when public health care and the world of the pubs are pieced together? What kind of challenges there are and how can we overcome these? This thesis also aims to highlight how an ethnographic approach can be applied in the process of solving the large-scale issue of health inequalities on a particular and practical grass-root level in the real-life setting of the pub.

1.4 Earlier Research and Theoretical Implications

To understand the historical trajectory and the background of the pubs in Finnish suburbs I apply thick descriptions written of the development of life in Finnish suburbia. Matti Kortteinen (1982) has analyzed how the rapid change in the Finnish economy from a rural to a modern industrial country changed the ways of lives for many people. Suburbs were built for the people who moved from the countryside to work in the factories and offices. This change of living environment also changed the distribution and nature of work and free time causing tensions within families. Neighborhood pubs were one peculiar place in this new environment. Ethnographic studies conducted in suburban neighborhood pubs in the 1980's describe the masculine communities that gather in these places. The pub provided working class men their own space, which was considered a space of carnival turning upside down the rules and morals of everyday work and family life. (Sulkunen, Alasuutari, Nätkin & Kinnunen, 1985) This research aims to follow the tracks of these two ethnographic accounts of life in the suburbs and their pubs as surrounding society has again changed in the shift from an industrial economy to a service economy. As a result, many working class men have become unemployed or work irregularly in temporary streams of employment.

To understand the background of the challenges of the Finnish health care system I have referred to the reports and statistics of the official quarters. (See for example Rotko et al., 2011 and Klavus, 2010) There has been a strong ethos of leveling health inequalities in Finland but officials have not been successful in narrowing the gap between socio-economic groups. The lower income groups and especially men suffer most from different health problems. To understand the gender issue in the relations to public health care I have applied the idea of multiple masculinities from Connel (1995). I contemplate the masculinities in relation to the feminine and bureaucratic world of public health

care, which I analyze through Max Weber's (1992) work on the ideal type of the bureaucracy. When analyzing the communities of the pubs as a platform of the health visit I apply the thinking of Pierre Bourdieu and Robert Putnam (2000) and their different ideas of social capital (See for example Siisiäinen, 2003).

2. Methodological Approach to the Challenge

Leveling of health inequalities has been traditionally viewed as a challenge on the macro-level. Alcohol-related health initiatives have, for example, been informed by an overall consumption theory (See for example Sulkunen, 1997). In these kinds of theories there are few key factors affecting the public good and they are altered through national policies. The viewpoint of the macro-level is important for understanding the scale of the different health challenges, but when operating and trying to solve problems on that level, it is possible to abstract people as average citizens and lose meaningful cultural differences. Understanding these cultural differences at play in the everyday we could actually find possible keys for solving issues in different cultural contexts. To understand the cultural aspect of the health issues we need to add that on the research tool kit of the public health care institutions in the form of cultural analysis.

2.1 Applied Cultural Analysis – Bridging Research and Practices

This is a Master's thesis of applied cultural analysis, which is a multidisciplinary approach developed to understand dynamics of everyday life embedded in a wider cultural framework. To form an understanding of the phenomena under investigation, cultural analysts apply the tools of the social and cultural sciences, including different theoretical and methodological approaches, to conduct the analysis. Based on the analysis we create applications for real life issues within multiple practices, teaming up with different kinds of practitioners. Knowledge of the experience of users and the mundane challenges potential customers face in their daily lives have become more and more interesting for businesses as the most user-friendly products and services that help to make people's daily lives better seem to succeed the best in the markets.

Business practices have been for a long time based on economical patterns and models that abstract people into average individuals equipped with rational behavior. It has not mattered that the theories do not capture reality as it is, as long as it has been successful to operate by using the models. Nowadays companies and even public authorities aim to provide better and better services for their customers and seek to come up with innovations that could change the ways we live. To succeed in this, more fine-tuned approaches need to be added to the toolbox of these institutions. Applied cultural analysis is a form of research that aims to contribute to this process of understanding the grass roots level of users and customers, and basing the improvements of practices on this understanding.

"...grasping life worlds and everyday practices of users and citizens is absolutely necessary to understand – and contribute to – processes of social change and innovation." (MACA, 2011)

The concept of culture can be a problematic one as there are different ways to understand it. The cultural section of the newspaper usually has stories of high arts, music and literature. Sometimes culture is referred to as the mental capabilities that differentiate people from animals as we have started using tools and since then cultivated our behavior and habits over the generations. In the research tradition of cultural analysis we understand culture in the widest sense of the concept. It refers to the whole way of living that is constantly in motion and being shared among people in changing ways. To understand how people live and what is important in this for a given practice, for example public health care practices, we need to study relations, shared meanings, and ways of doing things in different environments. We need to understand culture. This means going to the people and understanding their experiences, motivations behind them and meanings derived from them.

(Ruckenstein et al., 2011, p. 14-34)

2.2 Ethnography as a tool of cultural analysis

In order to understand culture we apply ethnographic research. Ethnography is not just a method; it is rather a collection of methods and an aim of understanding the perspective of the other, seeing the world from someone else's point of view. Words ethno and graph imply the traditional ethnographic endeavors of anthropologists writing ethnographies based on their fieldworks. Literally, ethnography means a picture of a nation and to draw these pictures anthropologists travelled to distant unknown countries to spend long periods of time studying people who have a totally different kind of culture. The traditional view of the sun helmet-wearing researcher entering an island of the indigenous people and observing the everyday action from the outside perspective has been outdated for about one hundred years, but some main elements of the anthropological tradition still remain as the core of the ethnographic research.

The goal of the ethnographic analyses has never been the sole observation, but also participation in order to acquire the insider's perspective. The aim is to understand the socially created meanings that are inherent in human life. Individuals are not studied in isolation from their social context; even in ethnographic interviews that are actually conducted one-on-one with individuals, the aim is to grasp meanings and practices that are shared. (Denny & Sunderland, p. 44-47) Traditional anthropology

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studied foreign, unfamiliar cultures in order to make them more familiar. Traditionally, going to the field has meant attending a new and unfamiliar place far away and the researcher's task has been to slowly familiarize himself with the strange cultural setting by studying the local people and their ways of lives. (Wolcott, 2008, p. 45.) Nowadays when we conduct research in our own society we first aim to make the familiar unfamiliar in order to be able to keep on questioning the presuppositions we always inevitably have.

Engaging in actual real life situations and applying participant observation as a method means that the outcomes and the plans of studies are always rather open. Change of plans is always an existing element of ethnographic research. It is impossible to decide that one will conduct fieldwork for eight hours at a specific place at a specific time with people who will give specific information. (Handwerker, 2001, p. 261-262.) Conducting the research in the pubs meant that we were entering the space where people come to spend their free time and relax, so it was not possible to know beforehand how interested they would be in talking about the health services. That is why in this project we first studied, discussed and asked for ideas and thoughts before actually trying out the health service pilot.

A typical critique of ethnographic methods is that they are unscientific since the results of the research cannot be validated nor recreated. However, the logic of the research is different to the commonly understood logic of quantitative analysis. Ethnographic research does not view the world from outside and give objective accounts of the one and shared reality. Culture is an always changing, on-going process and the researcher is never able to leave the social sphere or just forget their own cultural background, which always frames how they interpret the world. These issues result in ethnographies never being just reflections of the studied phenomena. They are constituted representations in which the researcher effects, describes and analyses. (Hammersley, 1992, p. 2-3.)

As an answer to critiques of ethnography is a field of research that has incorporated a strong idea of self-reflexivity. Social action never takes place in a vacuum that can be analyzed from the outside. There is always interaction between the observer and what is observed. Action is always by cultural notions of both the actors and the ones interpreting the action. (Denny & Sunderland, 2007, p. 50) The ethnographer is always part of the social, not a robot outside of it. As ethnography is something constructed it is always just one account of the world. Knowledge of the ethnography is not something that just claims to be revealed from the world, it is always produced in the practice of research. (Hammersley, 1992, p. 45-49.)

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Besides being criticized as not objective, ethnographic research has also been criticized for being unable to effect practices (ibid., p. 2). The idea of objective ethnography might not be plausible, since it is more a way of seeing the world rather than revealing the truth about it, but the production of a specific kind of knowledge can help to answer this second type of critique. Ethnographical methods lead us to take part in people's lives and engage in their experiences in order to learn from them. For the practitioners like private companies or public institutions integrating an ethnographic way of seeing as part of their strategy helps them to keep on asking new kinds of questions in a constantly changing world about the relation between them and their customers. What is it that is meaningful for our customers in what we provide and how could we provide something more meaningful? Cultural analysis and ethnographical methods imply an emphatic aim to understand people, their problems, needs and dreams. (Ruckenstein et al., 2011, p. 23-38.)

2.3 Cultural Analysis of the Gap between Public Health Care and Passive Customers

In this research the main methods were open discussions in the pubs with customers and staff members, group discussions conducted with the students right after the visits and the participant observations in pubs during the health visits. Visits themselves serve as a means of interaction and even intervention in order to understand what kind of gaps there are between the public health care services and the potential users and how those gaps could be bridged.

The field of the research is in the pubs of a neighborhood in Helsinki. The goal of this research is to form an understanding of a specific problem through studying aspects of it in these given locations. Pubs serve as a place through which to get access to masculine cultural forms that currently clash with the practices and culture of the public health care institutions. This does not mean that all men who attend pubs do not use public health care services and neither does it imply that all men who do not use any health care services could be found sipping beer in a pub during the day shift. Pubs were chosen as a place to reach these masculine cultural forms because a large share of the customers are middle aged men who have a high risk of typical health problems in Finland, and are most passive in utilizing the public health services. Day shift was chosen because people spending time in the pubs during the daily hours very likely do not have an access to occupational health care, which further elevates the risk of ending up not using health services at all.

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John Van Maanen (1988, p. 139-140) calls for new ways of tackling complex research problems by combining different forms of knowledge and methods of producing it. Statistical accounts, earlier research and historical trajectories of both the public health care and the neighborhood pubs, help in framing the meaning of the pilot project in the field. The aim of the fieldwork is to understand the dynamics in the micro level and discover how small changes in everyday life can be made. This ethnographic project is one approach aiming to open up a new kind of perspective on the challenge of public health care in reaching people.

A health visit is an encounter to negotiate health. The day shift is a context of everyday life in which people feel themselves healthy or sick, in which they consider their health more or less and behave in ways that affect their health. In the everyday practices of public health care institutions the living context of experienced health is easily forgotten. Ingrid Fioretos (2009, p. 39-40) describes how in the public health center in Malmö patients are categorized as groups based on their symptoms rather than encountered as individuals. This is done due to practicality, but it leads to routinized encounters in which these specific features are paid attention to and other features are left out of the picture. By taking health care to people in the pubs the whole practice is taken into another context, to a context where health is actually lived and experienced by people. Through the pilot our goals was also get a view of what this shift of the context of health care means for the customers and the professionals of health care.

3. Challenges of for the Public Health Care System as the Context of the Health Visit

The need for creating new innovations in health care services is an outcome of the historical and political trajectories of Scandinavian welfare states. Costs of health care are high and actors in the public sector have political pressure to become more efficient and influential. The municipalities organize primary health care in Finland. Many municipalities in Finland are currently struggling with their economy, which in public health care has for example led to outsourcing of the services and establishment of joint health organizations between multiple municipalities. These are new ways of arranging the services, but answering the health challenges we should also consider new practices within these services, or even new types of health services.

For all municipalities it would of course be economically, and not just economically, desirable to have a population as healthy as possible. On a national level Finland has had a strong ethos of leveling health inequalities between different socio-economic groups, but despite political programs inequalities have been on the rise. (Rotko et al., 2011) At the same time, as municipalities are struggling to produce efficient public services, the service providers also have the problem of reaching some of the potential users who could benefit from the services. Men, who have health risks and don't use or even avoid public services, pose a real challenge for the institutions of public health care.

Traditional health promotion in Finland has been in the form of educational information on the risks of especially smoking and alcohol. (See for example Koivusalo, Ollila & Alanko, 2009) This doesn't seem to work in all cases. Despite campaigns and education, the overall consumption of alcohol, for example, has been almost steadily growing over the past decades (Rotko et al., 2011). Scandinavian welfare societies being one of the most educated societies in the world, the adult people who engage in unhealthy activities are often aware of their unhealthiness. The main problem doesn't seem to be the lack of basic information. Discussions in the pubs also fed this hypothesis. People knew that alcohol and smoking are harmful and many felt they had heard it enough times. It says "smoking kills" on the cigarette pack and they can read. The amount of health promotion based on the educational information on the risks of alcohol and tobacco led us to consider and try a different

approach. It was possible to discuss alcohol and smoking in the health visit, but they were never a starting point for the discussion or the initiative of the nursing students.

3.1 Men and Health in Finland

“Why do the healthiest babies in the world take their own lives away?”

-Finnish proverb of the suicides and reckless health behavior in the country of excellent maternity and newborn health care

Men are expected to take care of themselves, to take hold of themselves. In general men do not spontaneously attend medical examinations until they have some symptoms of illness, which in many cases is late, especially for an aging man. This is a national problem in Finland. Finnish men are an endangered species. They die because of heart attack, get diabetes, or kill themselves (Nurmenniemi, 2008). Men in Finland drink and smoke more and behave more carelessly regarding their health than women do. On average they die younger and live an unhealthier and riskier life than women. Young men have a higher risk of dying or being injured in traffic and due to violence. Middle age men have higher risks for lifestyle diseases such as diabetes and cardiovascular diseases. Mortality rates have a drastic gender difference and the life expectancy of women is 6.3 years longer (Statistics Finland, 2012).

Mortality by Sex in Finland

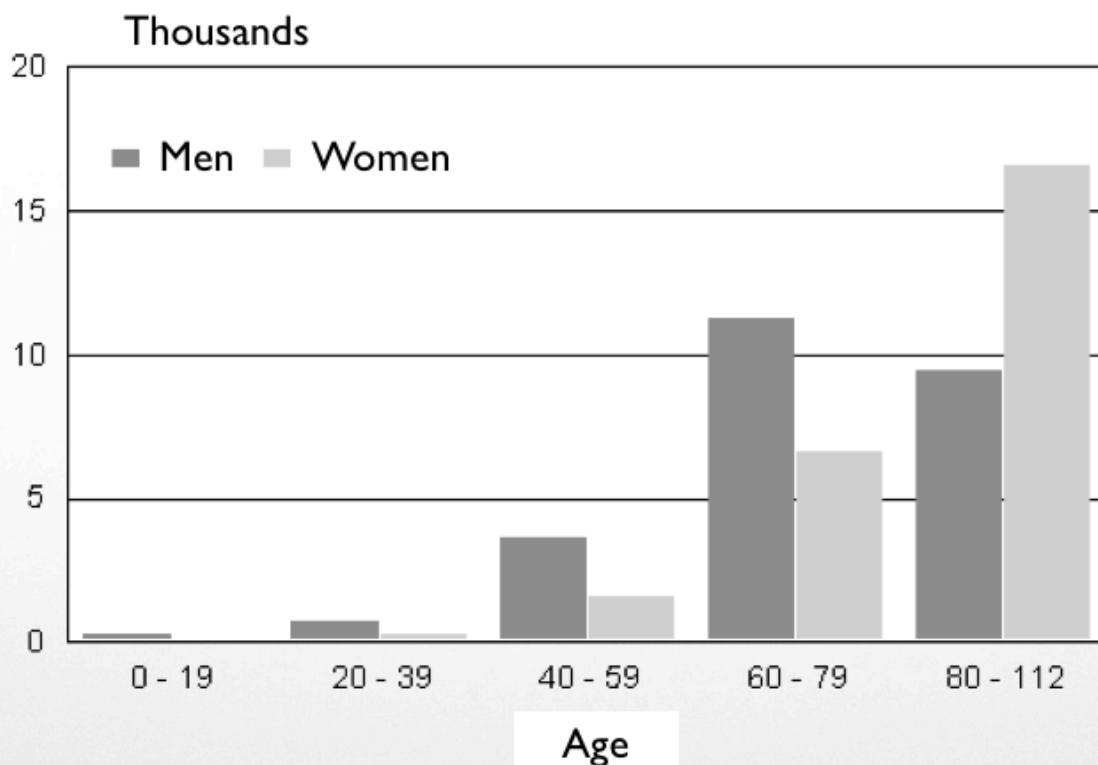


FIGURE 2. Mortality by sex. (Statistics Finland)

Dangers to the men seem to be rather universal. Biological reasons or even psychological measurements don't explain the sex differences in health statistics. Connel (1995, p. 21) sums the research on psychological differences as the defining factor: "Sex differences, on almost every psychological trait measured, are either non-existent or fairly small. Certainly they are much smaller than the differences in social situations that are commonly justified by the belief in psychological difference." Difference in the health risks is due to the difference of social situations that men and women end up in their lives. It is based on the cultural perceptions of what it means to be a man and what kind of behavior that involves, and how it affects health. Some of the cultural messages sewn into the cloak of the male gender can put men at risk for illness and early death (Sabo, 1995, p. 256).

Male stereotypes have been used in commercials to promote for example drinking beer as a reward for a job well done or smoking as a part of male adventure. Stereotypes don't affect everyone the same way and there is no one men's health but multiple contexts of cultures and socioeconomic

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status that intervene and affect the statistics. There are multiple different competitive masculinities in which manhood is acted out differently in different situations, times and places. (Ibid., p. 246-247) In this project we took a closer look at one particular space and its relations of masculinity and health. Improving health and well being of men needs to be contextualized in different ways if we are to affect the statistics of male mortality and illness. Neighborhood pub is one dominantly masculine space in where we can start to consider what health is for the men there, and how their health concerns could be better served through that space.

As Simone De Beauvoir (1949 / 1989) once put it you are never born as a woman – you become a woman. Gender is an outcome of a socialization process in which you learn what is expected, what is impossible and what is rewarded in being a woman or a man. Currently, growing to be a man seems like a risky process in Finnish society, but it is important to note that it is not biologically determined, but a culturally produced gender position. Contingent features of gender for men in Finnish society currently include features that weaken your health and life expectancy. The equality movement that has paid attention to men's issues is rather small, but some of their observations seem to call society for action: "Men die approximately 7 years younger than women. You would expect that of all groups men would be the one to pay extra attention to." (Petäys, 2007) Perhaps there is less sympathy towards men in health care, since they are considered to be strong survivors or the ones causing themselves harm. At least it seems that there is a lack of empathy towards men who don't use health services. It is difficult to understand health care from their perspective.

3.2 Public Health Care as an Integral Part of the Welfare State

"There used to be everything here. Now we don't have a bank, post office or a health center. There are just bars, 5 or 6 bars in this small area."

-a customer of a pub sitting in the terrace

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Scandinavian countries are considered to be examples of universal welfare states of a social democratic welfare regime. This means that everyone is entitled to a reasonable basic income and the same common public services. (Esping-Andersen, 1990.) A high quality public health care system has been one of the backbones of the universal welfare state in Finland and health centers are places where all residents of the municipality can attend when they need health care. Universality of the welfare system means that all services are provided for everyone. It is a form of joint social and health insurance for all residents. Most of the health care is publicly produced and funded in Finland. The Finnish public health care system is twofold; municipalities take care of primary health care, which is organized in health care centers. Specialized health care is organized on the level of larger districts of multiple municipalities and takes place in regional hospitals and university hospitals.

Municipalities are responsible for organizing public health care and they fund it from the municipal tax paid by the residents of the municipality and the subsidies received from state. Municipal health care started in 1960's and is still very much operated in similar principles as back then. Encounters with municipal health care centers are based on proactive initiative of a patient. You contact your local health care center and reserve an appointment with a general practitioner or public health nurse, or you attend the health center duty after office hours without a reservation. In the case of a more severe problem, a doctor directs the patient to specialized health care. Nowadays, approximately 95% of cases are handled at the health care center by general practitioners and nurses and 5% are directed to specialized health care.

Public health care is considered to be practically free, but you need to pay small fees for the appointments. Sums change between municipalities, for example a visit to doctor in the evening or weekend hours costs 27,40 € in Helsinki. There is a limit for yearly payments in public health care to ensure that even a more severe health problem should not be an economic catastrophe for anyone. There have been political discussions over how the small fees affect the use of the services and the health inequalities between socio-economic groups. Some consider the small fees to be a hindrance for the poor to use the services in the first place and it is also considered to be unfair that people who attend occupational health care do not have to pay any fees as pensioners, children and unemployed pay the fees at the public health center. Small fees are, on the other hand, considered to be good way of covering at least some amount of the cost by the actual use and they are to confirm that people don't abuse the system by making constant unnecessary appointments.

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Besides the municipal health centers, public primary health care services are offered for the pupils in schools. Employers offer occupational health care either in the public health centers or private health clinics. Typically, people access the health care through their daily institutional contexts. As a kid you go to school and meet the school nurse every year and when you go to work you get the occupational health care and meet the nurse or doctor every now and then or whenever you need a sick leave. Private clinics organize the primary health care for a large share of Finns in the context of occupational health care. There is a fear, often presented in public discussions that since the middle class is now attending occupational health care instead of municipal health centers, these will become lower class clinics for the people outside of the institutions with occupational health care. (Koivusalo, Ollila & Alanko, 2009.) The numbers of the health centers has been decreasing and not just in the countryside, but also in Helsinki - they are no longer available in every suburb that they used to be.

This fear is based on the fact that institutional life paths have become more shattered and the move from school to 8am-4pm workplaces is not the only obvious choice anymore. Common life paths defined by social factors used to be strong normal biographies guiding the everyday life of individuals normatively setting certain life phases to certain ages. (Beck 1986, p. 214-216 in Jokinen & Saaristo, 2004) As unemployment and temp work have become common more and more people are outside of the daily reach of traditional institutions. What happens to the relationship to health care when the workplace or school system is not there to provide regular health check-ups? Could there be alternative institutions of everyday life that could be utilized by the public health care to reach people and offer possibilities for health services? Could pubs serve as one of these alternative institutions?

Health Care in Institutional Contexts

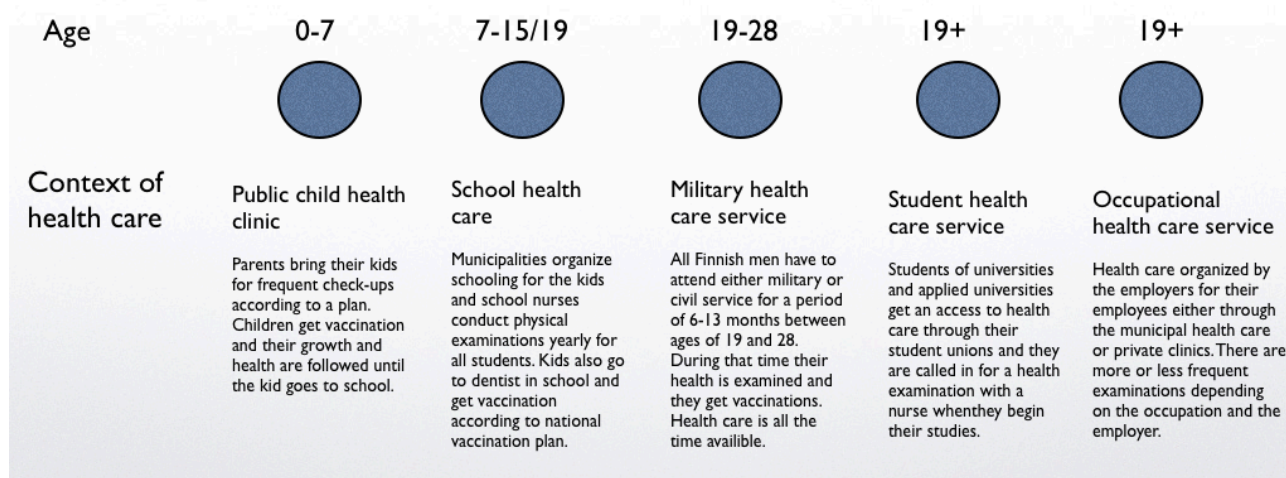


FIGURE 3. Health care of men is part of the institutional life path.

Calls for efficiency and productivity mean that doctors, for example, typically have only 15 minutes for each patient and the queues and waiting times at the health center can be long. This is well known by the residents. The hurried nature of service in the health centers and the fact that, as a first point of contact, you “only” meet the general practitioner, has given rise to a discourse in which health centers are called “the guessing centers,” as some of the respondents we met in the field also call them.

3.3 The Economic Challenge of Public Health Care in Scandinavian Welfare State

Municipalities fund the public health by municipal taxation and the benefits from the state. This has become challenging since the costs are rising for two main reasons. Firstly, as medical science has developed, the expectations regarding health care have also grown in the same pace. Variety and amount of care procedures have raised the costs of health care. Another factor affecting the costs to rise is the ageing of the population in Finland. The health care situation and life expectancy in other Scandinavian welfare states have developed in a similar manner and all countries with aging populations are facing challenges in the organization of health care.

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Discussion of financing and organizing health care is a political discussion concerning the very nature of the welfare state. Over the past few decades the problems in funding of the Scandinavian welfare state have become more severe, tax percentages higher, and states more indebted. Expenses and incomes are not in a long-term balance and practically all political actors acknowledge that something needs to be done. As an example, it has sparked initiatives to involve citizens in the production of welfare services that used to be handled by the public sector. This has resulted in intensifying calls for the third sector of citizen associations to join in. More recently, social enterprises have been another hot topic in the discussion about the problems of the welfare service production. The idea is to outsource services from state and municipalities to other non-profit actors or “responsible for-profits” as the social enterprises could be coined. Regarding the health care there have also been demands for bids to private companies to take over some parts of public services and increasing the responsibility of individuals over their own health care (Saarinen, 2010, p. 11-12).

Discussion of improving efficiency in health care also revolves around the theme of responsibility. What is the responsibility of the individual over taking care of one’s health? What kinds of health problems are self-caused and should the public or the individuals who have caused them pay for the treatment themselves? Universal model is based on an idea that health problems are not self-caused, and not to be left on the shoulders of unlucky individuals or families facing them. The universal welfare state acts as a general insurance system with all of us taking part in sharing the risks and costs of health and social problems.

A healthy way of living is promoted through public policies and campaigns against, e.g., irresponsible drinking or smoking. Unhealthy lifestyles are indirectly taxed in the form of a high VAT for products such as candies and cigarettes. During the last decade emerging themes in the public discussion have also been on whether the people who have unhealthy living habits, who smoke or are overweight should pay more for their treatment than the ones who try to take care of their health, but are unlucky and get ill. These kinds of ideas to promote health consider the fear of punishment to be the tool for behavior change. Would the people who don’t currently make good use of public health care services and live unhealthy start taking care of themselves if the health care services would cost them more because of their unhealthy weight, smoking, or drinking?

If we take the customer-centric approach seriously we rather ask how different people perceive health in different contexts and how they take care of themselves and each other. Could we find meaningful ways of integrating the health care into these contexts? Could we give tools to that caretaking, and could that help us to improve our health care system and reach people outside of traditional institutions?

3.4 The Healthy Neighborhood Program as an Innovation Platform

Public authorities in Finland often try to solve social problems by organizing projects that aim to provide new innovations that would solve problems. The Healthy Neighborhood program was a 4-year long innovation program run by the Health Care Center of the municipality of Helsinki. The aim of the program was to produce new services and tools for the residents to improve their health and well-being. It was carried out as a living lab project in a specific neighborhood in Eastern Helsinki that served as a real life testing ground for the services. This area was chosen because it is statistically most representative of the whole of Helsinki. It's a wide and diverse area with residential areas from upper middle-class detached housing by the sea to traditionally working class concrete suburbs.

The program began in 2008 and ended in the end of 2011. It was a partnership program that brought together actors from public associations, local organizations, private companies and the municipality of Helsinki. In the program, the health care center facilitated cooperation between multiple actors from grass root level associations, libraries and companies to research organizations. Day shift in the pub was one of the sub projects of the Healthy Neighborhood program. Others included for example projects that introduced exercising equipment to be lent from libraries, retail clinic that provided health services at a mall and a mobile dental service unit moving in a truck from a schoolyard to another.

Helsinki faces similar challenges as other municipalities in Finland and the aims for improving the efficiency and influence of health care go hand in hand with the preventive and proactive approach of enhancing healthier lifestyle in the neighborhood level. The program had three main aims, the first being the general promotion of health. Second, increasing individual responsibility and giving new possibilities for activities that help people independently increase their health and wellbeing. The third aim was the acceleration of the use and launching of electrical services and well-being technologies. By tackling these challenges the program aimed at balancing the health inequalities between different demographic groups and stopping the growing of the costs of health care. (Terveellinen kaupunginosa, 2011.)

3.5 Sorting Attachments in the Project

In applied cultural analysis we work in close collaboration with different organizations that might have different objectives and orientations that we need to fit into a collage that will serve and satisfy all stakeholders. We also need to acknowledge that we have to be careful in our aim to stand firmly, one foot rooted in the academic tradition of ethnography and the other in the world of practitioners, businesses and organizations. In the field the attachments are never just open for sorting to researcher but there are existing ways of organizing them and expectations that have to be understood when conducting an applied research project. How we conduct our research, what theories and methods we use, and how we communicate our research always affect how we are relevant to different stakeholders around us. Sorting attachments refers to this cohering researcher needs to consider between theory, research and the practices it affects and is part of. (Jensen, 2007.)

In practice this is done by figuring how to engage with different stakeholder institutions, their agendas and cultural backgrounds in order to take these into account in conducting the research. (Ibid., p. 239.) It is a challenge for a cultural analyst to work as an intermediate understanding the values and goals of different stakeholders involved in the process. Sometimes one needs to be able to convey analysis in a manner that reconciles even the seemingly contradictory interests of different stakeholders. (Jönsson, 2008 p. 81.) In this project I was working in the institutional context of my employer Gemic and our main stakeholder was the client, the Healthy Neighborhood program. Through them we got into connection with Metropolia University of Applied Sciences and their students and teacher who are to thank for the actualization of the health visit pilot. A group of nursing students carried out the pilot in practice as a part of their course in health promotion. The generous attitude of the owners and staff of the pubs also made the pilot possible. They are the true professionals of their environment and were really important enablers and cooperators for the students in the pubs.

Stakeholders from the public sector came from a strong background of public health care organizations and the cultural traditions of Finnish health care. For the official institutions of health care it is uncommon to cooperate with local neighborhood pubs. At a first glance they seem to have a conflicting agenda, as pubs are private companies whose income comes mostly from selling alcohol and sometimes also fatty food. Health care institutions on the other hand promote healthy behavior

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and give instructions on the risks of smoking and drinking for example. The typical form of health promotion in Finland has been campaigns highlighting the health risks of drinking and smoking by posters, educational videos and leaflets.

Through legislation it has also been made difficult and expensive to purchase alcohol and tobacco in Finland. A lot of organizations promote political actions to reduce the overall amount of alcohol consumption and smoking of tobacco. As these are the items that the pubs sell and many people do drink there and smoke outside of the pub, it could seem like an unsuitable place for a health service from both sides. For the pubs it could be bad for the business to have nurses come to the pub to preach about the dangers of smoking and drinking as everyone has already heard of them. Instructions are part of school education and it even says in really big letters on the cigarette packs that “Smoking kills.” People are not stupid and they understand that some of the things they do are unhealthy, but nobody wants to hear that in a pub where people come to relax. On the other hand it could be considered as the wrong place for healthcare to take place. Presence in pubs could be interpreted as an approval of an unhealthy lifestyle that healthcare was supposed to fight against.

It turned out that the framing of the health service was very important. It was not to be a fight between different rational and cultural backgrounds. People at the pubs usually first laughed a bit at the idea, but as we discussed further they thought that under few conditions it could be a really good idea to have a possibility for a health care service in the pub. It could work as long as it wouldn't judge choices on drinking and smoking, but would let people negotiate and get information of them on their own terms. From the side of the health care it was on the other hand very important that the service would in no sense promote alcohol service. We relatively easily found two neighborhood pubs that would be able to piece these together and they also saw the benefits that service could have for their customers, and for them as a place that was also engaged in promoting health.



FIGURE 4. Stakeholders of the project, their roles and aims.

3.6 Cultural Analysis as a Different Approach in the Field of Health Care

“Human culture is not something to be caged for display, put on a slide for inspection, read from an instrument, or hung on a wall for viewing.”

–John Van Maanen (1988)

Working in the field of applied cultural analysis we take our approach to multiple fields of different practices in order to produce insights, which could help these practices create new value. We are accustomed to conduct a double cultural analysis, analyzing both the world of the customers and the world of the organization we are working together with. (Damsholt, 2011) In the case of public health care institutions there is also a need to position ethnographic research in relation to the default research tradition of medical science in which the practices of public health care are based, at least in when it comes to care. Because of the differences of these research traditions I shall try to build an understanding of the possible role of ethnographic research in relation to medical research. Decisions in the caretaking activities are based on best current knowledge produced by the medical sciences.

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Statistical analysis and quantitative evaluation serve as traditional mechanisms suited for health policies (Jensen, 2007, p. 241). Ethnographic research does not give clear answers for the treatment of patients, but rather opens up new traits of thought regarding what could be considered when this treatment is being organized.

There is also a potential cultural clash where these two different types of research traditions intertwine in order to explore and enhance best possible practices of health care. Ethnographic research is based on the interpretations of the observations of the researcher. Interpretations actively take part in constituting social reality, which differentiates ethnographic inquiry from the traditional models of natural sciences. (Hammersley, 1992 p. 45-48.) In natural science the object of the study is the discovering of probabilistic and generalizable laws through studying and describing particular happenings. The idea is to uncover the laws of the nature as they are, as precisely and incisively as possible. The aim is to find laws that have predictive power, which gives people a higher degree of control over the environment for example in a form of medical treatment. Theories are hypotheses of these laws and they are hierarchical of nature, the law of generality from which lesser laws can be reduced, being the highest in the hierarchy. (Pratt, 1978 p. 69-72.) Discovering the truths of nature as they are implies an objective distance from the studied objects. The aim is not to interfere nor change the world, but describe it as an observer from above like a researcher in a laboratory can study their small study objects through a microscope.

Ian Hacking (1999) proposes the nature of the objects of the studies as the main difference between social sciences and natural sciences. Objects of natural science are not interactive like the object of social science. Bacteria and viruses don't have an attitude towards or change their behavior based on the descriptions scientists or doctors make of them. People on the other hand can read, comment and discuss classifications made of their life.

Social issues are not deterministic. They do not have to exist or remain as they are and they are not necessary outcomes of trajectories. Culture is in constant flux and things change all the time, thus making social research a kind of reflection process of the on-going process of culture and society. Social science as a reflection is a process of exploration and description of the world. Nature on the other hand is often considered as something that has a structure that scientists are aiming to uncover, fact by fact when studying it.

Facts are objective facts when they are uncovered through methods that meet the scientific standards. Following of certain patterns in the process is to ensure the objectivity of the knowledge. Hypotheses

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are based on earlier research and tested by experiments. Through experiments, knowledge is supposed to accumulate and laws become more and more confirmed or falsified. In practice this is never straightforward. People in all sciences always need to fabricate order from a more or less chaotic collection of observations, in natural science it is important to demonstrate that this is done correctly by using a valid method. (Latour & Woolgar, 1986 p. 36-37.) It is always a struggle to produce order and you need to eliminate alternative interpretations and render these alternatives as less plausible in order to be able to produce scientific facts. This production involves choice and creativity when a scientist moves from the mass of evidence to a scientific conclusion (McComas, 1998 p. 53-70). The ongoing and shifting process of the production of natural scientific facts and laws is apparent when you consider how they have changed over the course of history. New means and new technology bring tools for producing new science, that changes the current conceptions of truth.

In cultural analysis we do not aim for the objective truth, final explanation, or even the most objective and latest knowledge to base procedures on. We neither come up with probabilistic laws or quantifications of features in the world. We aim to explore the culture, trying to catch a human phenomenon and to describe it in a fruitful way that opens up possibilities for further contemplations. By having a qualitative description of a phenomenon it also becomes more easily measurable and experimented. The cultural analytic research paradigm is not about having objective distance. We are never outside of what we study, but a part of it, involved in the process of discovery, knowing and understanding with the respondents. The process of cultural analysis must be one that is constantly questioning what we consider as given and clear. Are we right in what we think we know, and why do we think we know it? (Denny & Sunderland, 2007 p. 47-48.)

By taking cultural analysis to the field of public health care we can question the current procedures and preconceptions, thus challenging also what is considered as given. How is health perceived and acted out in different places and how do these play together with the way it is perceived in public health care? What are the other options and what happens if they are to be tried out? By asking these questions we can bring a new aspect to health promotion. For John Van Maanen (1988, p.141) the value of ethnography lies not in it's analysis, but the decision of studying culture in the first place, to conceptualize it, reflect on it, narrate and evaluate. This also opens up possibilities for further research from different points of views including the medical science and especially the considerations of the influence of medical care.

4. Neighborhood Pubs as the Context of the Health Visit

Ingrid Fioretos (2009) studied the interaction of public health care and immigrants in Malmö. According to Fioretos (*ibid.*, p. 113-114) structural issues in society become interpreted as individual health problems in the public health care system. People who are poor and don't feel they can keep up with the surrounding world or people who can't explain their problems often end up with diagnoses of depression and other mental problems. Traditional masculine working class culture also seems to be in some kind of clash with public health care and this is also embedded in the social trajectory of the neighborhood pubs in Finland.

After the Second World War, Finland was one of the fastest urbanizing countries in the world. In the level of families this meant that large farming households were left by the children who moved to urban areas for new kind of industrial occupations when they grew adults. Mass movement of people was facilitated by rapid construction projects of high-rise building in the outskirts of towns. Concrete suburbs became the homes of the new urban working class, which had its roots in the soil of countryside fields. This new setting changed the lifestyle of the people in drastic ways and the neighborhood pub of the suburb was one special location in this setting. The historical trajectory of the pubs as masculine gathering places is important in understanding the social dynamics of the pubs and the reputation pubs have. Pubs still remain as gathering places in which people can utilize each other's knowledge in many ways to tackle different kind of challenges, but health issues are currently not high on the menu.

4.1 Great Move as the Origin of the Finnish Suburbs and their Neighborhood Pubs

Finland hosts thousands of small pubs, bars and restaurants that open their doors as early in the morning as 9:00 AM, when, according to the Finnish law, you are allowed to start serving alcohol. A great number of these pubs and bars are located in concrete suburbs that were built in the 1960's in the peripheries of large towns during The Great Move, when Finland turned rapidly from an agricultural society into a modern industrialized nation state. The sons and daughters of the farmers became blue-collar workers, salespeople, and office workers. As a mass of young people moved from the countryside to the towns for work there was huge demand for housing. Politicians

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cooperated with construction companies to start large scale housing projects in order to accommodate these new workers and their families in the newly build high-rise suburbia of the towns.

This was the first generation in Finland with separate work and free time. Urbanization and free time brought along the consumption culture. Living standards were rising quickly, televisions became common, middle class people started travelling to foreign countries and the level of alcohol consumption rose significantly. Traditional gender roles and the values of peasant work and countryside neighborhoods became pressured by the new settings and new ways of life. (Sulkunen et al., 1985, p. 26-27) Young men and women came from the families of independent farmers where everyone worked together on the farms in the rhythm of nature and people lived with their large families in big houses and knew everyone in their village. Suddenly they were working for set hours in paid occupations in offices, warehouses and factories. The change in physical environment was also stark - from the houses in countryside villages to small apartments in concrete suburbs.



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PICTURE 1. Typical Finnish suburb consists of functional high-rise buildings and concrete. It's surrounded by nature and situated approximately 15 km from the center of the town. CC-licensed picture from <http://ngophotos.dodo.org> by Antti Ammunet.

In this historical context pubs in the suburbs became common rooms for men who had been torn from their roots and moved from the countryside to the new concrete neighborhood. In the pubs they could gather to stay connected with other men of the neighborhood. This had been an important feature in the self-supporting way of life in the countryside, where neighbors relied on each other's help when it came to harvesting, construction, and repairs. Pubs became sites where men of the suburban community gathered together in the same manner as they used to in the countryside communities. They discussed work and family issues, had some beer, and played darts or billiards. (See for example Kortteinen, 1982 & Sulkunen et al., 1985.)

The surrounding society has kept on changing in many ways since the 1960's, but the physical setting of the suburbs has remained. Pubs in the suburbs are still manly sites and their amount has been on the rise as other services like banks, post offices and supermarkets have left the dated suburban malls. After work -gatherings, that were the most common ones back in the days have now become accompanied by morning and midday happy hours, and the serving of alcohol has become easier as restaurants don't have to sell food in order to have an alcohol license. The menu on the places that do sell food has also changed from the traditional Finnish dishes to pizza and kebab. In most of the cases the main source of income is beer that is sold in one or few sorts on the tap. Nowadays there are more immigrants living in the suburbs and also immigrant entrepreneurs often own the pubs.

4.2 Neighborhood Pub as a Setting



PICTURE 2. Picture from one of the pubs during the health visit.

This picture is from inside of a typical neighborhood pub. There is a counter from where you order and where you pay for your drinks and food as you order. At the counter there are a few seats on bar chairs. During the day shift bartenders usually have time to chat with regular customers who are sitting on these seats. Over the time they have often learned to know each other quite well. On the counter there are two beers and one cider on tap and these are the bestselling products of the pubs. You can also order soda, coffee, stronger alcohol drinks and pizza or kebab to eat.

Customers often sit in booths of 4-6 people with tables, which may have more or less regular visitors who usually know each other from before. Many have lived in the same area for decades or even all of their life. The typical interior of the neighborhood pub is quite dark. There are a lot of wooden or wooden-looking surfaces and leather seats. In one corner of the pub you will find a gaming machine of poker or fruit game, from which you can win some coins if you get lucky. These are provided by RAY, which is a monopoly organization funding Finnish welfare and health promotion. Flat screen

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TV has become standard equipment and it is on if there is ice hockey or other sports that Finns are good at. Pubs also always have daily tabloids (Iltasanomat, Iltalehti) and weekly tabloids (7 päivää) with entertainment news and gossip, which can be found on the tables or counters, and they serve as an easy starting point for conversations. Sometimes you can also find other magazines like Tekniikan maailma, a magazine called “the world of technologies”, which has articles on the latest technical equipment and comparison tests that reveal the rank of current best stereos, computers, or cars.

4.3 Pubs as Gathering Places of Men

Pubs are places where people come to relax and enjoy a drink while discussing with others or reading the tabloids. The pub is a place to meet friends and catch up on the latest of their life and the life of mutual friends. With other customers who are not such close friends, one can always discuss on a general level about the current issues in news or safe topics like cars and sports. It is relatively easy to start a discussion on a general level. In this sense sociability comes close to what Simmel (1999, p. 112-131) calls "Geselligkeit", a playful social form in which discussion has a value in it, keeping up the sociability. Discussion as geselligkeit is not too personal, but, while remaining tacitly aware of privacy, needs to have interesting topics in the form of shared discourse like a discussion around common hobby.

Pubs are very informal places. People do not dress up like they would for nightclubs or restaurants. You can come casually as you are. People sitting in the pub during the day shift are dressed in varied manners. You can see middle-aged men, who just came by motorbike, dressed in leather. They might have a coffee or a beer and a chat with friend while playing some coins on the poker machine in the corner of the pub. You can also see younger men in their hip-hop-style clothing and you can see women from the suburb chatting with their friend who works at the pub. Most customers are locals who live nearby or have connections to the area in one form or the other. They might have previously lived there or worked there and know a lot of people who come there because of that. It is rare that somebody would come for a neighborhood pub from another part of the city.

During the daytime it is mostly regular customers from the neighborhood, who populate the pubs in the suburbs and most of them are men. These used to be places for the working class men to gather after the decades of 1960's. There are still some of the same men who moved from the countryside to

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work in the city and now in their late middle age and have different kind of life stages behind them. Structural changes in the economy demolished a lot of the industrial occupations these men took up after moving from the countryside and tensions in families have increased the numbers of divorces. Matti Kortteinen (1982) describes how the patriarchal model in which the family was responsible for taking care of their farm and economy together came into crisis at the suburbs.

When families moved to suburbs from the countryside, family ties were no more based on the distribution of work within the family, but merely on the emotional relation between the partners. The task of the women became much easier thanks to the development of kitchen and cleaning equipment and they had more time to spend with the children. The patriarchal organization of the family became tense when women became fully dependent on the husbands and their salaries from paid work outside of the family sphere. The majority of the women gradually joined the workforce, but household chores remained as the women's tasks. The doubled shift of the women put pressure on the power relations within families. Traditional men's work and even men themselves were no more irreplaceable.

If the emotional ties of the marriage fell apart there were three possible solutions for a man. You could become softer by taking part in care taking and home duties considered as female and thus enhance the emotional ties of the family. On the other hand you could become a successful economical provider of the family, securing wellbeing and rising living standards for the family. The third option was to escape from the sphere of the family to somewhere you could still hold on to traditional Finnish working class masculinity. Local neighborhood pubs often played a role in the third option, which often ended in marital problems and a divorce.

In most cases it has been women who have retained the custody of the children, as men remain alone (See for example Sund, 2007 and Roos, 2007). Men who spend time in the pub during the day shift are retired, working temporarily every now and then, or unemployed. They gather with others to relax, discuss, and just read the daily tabloids. Some pass by and sit down for a while to chat and others stay for many hours sitting and sipping beer or coffee. People who regularly come to the pub and people who work there form a loose social network in which people recognize each other, know each other by name, or are even really good friends with each other.

4.4 Bad Reputation of Pubs – Negative Stereotypes of the Day Shifters

“There they are just sitting in the crappy pubs all days, wasting time and money, just getting drunk.”

-A passer-by from the neighborhood

The historical trajectory of the crisis of the patriarchal family model is one of the reasons why neighborhood pubs have had a bad reputation in Finland. It was not uncommon for these marriage crises to end when the man was seeking freedom through alcohol in the local pub. (See for example Kortteinen, 1982 & Sulkunen et al., 1985) Numbers of divorces have been on the rise since 1960's. Divorced men with personal problems often also have drinking problems and pubs are stereotypically considered as some kinds of nests or starting points of these problems.

Stories of men losing their place by the erosion of patriarchal family model have produced male stereotypes of men who have nothing to do, can't manage financial or any other responsibilities and just spend their time adventuring outside of home with their male buddies. The pub is both outside of the sphere of the home and outside of the sphere of productive work.



PICTURE 3. Uuno Turhapuro, in the middle of the picture, is a popular movie character capturing the problem of the uselessness of traditional masculinity. He lives in a city, he never takes part in housework and focuses his energy on adventures outside of home and family with his male friends Härski and Sörsselsön.

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Stories of popular culture, such as Uno Turhapuro movies are a typical way of reproducing stereotypes through symbolic discourses. Stereotypes define people by simplifying behavior or features and highlighting chosen aspects. The term stereotype derives from Greek words meaning “solid impression.” By defining people in simple terms stereotypes hold people in place, blocking all change. Stereotypes of working class men are produced accounts and images of the working class masculinity which are conveyed by the media and by people in discussions, both face-to-face and in media. One of the commenters in an online news story about the health visit at yle.fi, the website of the public radio and television broadcaster of Finland, serves as a good example of how popular prejudices are conveyed in public: *“People who hang out in the bars of the suburbs are the worst customers for doctors: unclean, over-weight, booze-smelling middle age men in terrible condition. When you don’t have any life control it doesn’t help to prescribe recipes. A man has to take a hold of him and renovate the whole way of life. Cemeteries are full of those 40-50 year old men who were bragging that smoking and drinking does no harm to them and having fun without alcohol is faking.”*

Prejudice and negative stereotypes of the places also cast a shadow of a stereotype on the people who spend time there. Serving of alcoholic beverages itself defines the pubs in many ways since the position alcohol has in Finnish culture is such a disputed one. There are contradicting discourses around alcohol. State authorities, researchers and third sector actors are often worried about the citizens’ excessive use of alcohol and a common paradigm is the aim to reduce the overall consumption amounts through different policy acts. (See for example Sulkunen 2007)

According to Wikipedia, which is not a valid scientific source, but a good indicator of national stereotypes, drunkenness has not been considered as shameful in Finnish culture. Vice versa it is praised and considered as a sign of sociability. Finnish stereotypes of alcohol use lead to stereotypes of Finnish men. Common stereotypes, especially well known for Swedes, of Finnish men have to do with alcohol, drinking too much of it, being brutal, drunk, and violent. In some way it has been seen as a great act of masculinity to be able to handle huge amounts of alcohol.

Another important institution, besides the use of alcohol, shadowing Finnish men through stereotypes is physical labor. Finnish men are considered to have *sisu*, it is a positive stereotype of persistent, hard-working men of the North who never give up. As Väinö Linna begins the legendary story of the nationalistic imagery, “In the beginning there were swamp, hoe and Jussi...,” where Jussi is a Finnish man who single-handedly turned the swamps into lucrative fields. Nowadays, this hard-working masculinity in the urban areas is restricted to the field of employment. Being outside of

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this field deprives this stereotype from being used as a source of pride. Even though the institutions of work have changed, traditional labor is still related to labor hours of the day shift, which casts another stigmatizing ray on the day shifters, who are potentially engaging in the acts of reckless free time during the time socially designated for serious work. In research done in the 1980's, restaurants and pubs in the suburbs were found to be structuring the shared values and ideals of good life in the suburb by being the contradicting negative example. (See for example Sulkunen et al., 1985.)

Explaining this project to outsiders often evoked a thought of us somehow trying to help alcoholics who have problems, which was not the case. Idea was to offer a chance for positive encounter with an interesting health service that evokes interest on health among the customers of the pubs.

Customers of the day shift seem to be often considered by the outsiders as somehow excluded from the decent everyday life of a person who does his job well during the day and then takes care of his family and exercises in the evenings.

For some, pubs may still serve as a place for escapism, as a lot of people have problems and alcohol is a very common self-medication for personal problems, and it is often consumed in the pubs.

However, the idea of the pub as the source of personal problems, or as the main amplifier of these problems, is often more wrong than right. For the people who do spend time at pubs there are also positive effects. At their best, the social networks formed around the pubs can be a great source of social capital with many positive effects.

4.5 Pubs as a source of Social Capital

"I got divorced after 20 years of marriage. After the divorce I was dating this woman for a while. Once she came down here (to the pub) and asked: "Why do you always sit here with this kind of losers?" I stood up and told her "You can blame me and call me whatever you want, but don't you come here and mock my friends!" and you know what happened? That relationship with her ended right there, on that spot."

-Story, told with pride by one of the respondents

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This story is a good example of how strong the relationships between groups of men can grow over the time as they gather in a regular place. Friends become important; they are the ones that can be trusted on over anything, whatever happens. Blaming people as important as this is an insult too hard to accept. Sharing of stories and possible hardships such as previous divorces and family issues, has built companionships. Regulars in the pubs can form groups that hold tight together and serve as a source of information, advice and support. People discuss their aims of buying new vehicles, choosing a travel destination and quitting smoking. Different options are weighed with others and common reflections flow in open discussions.

These kind of social networks are often in social science referred to as sources of social capital. There are two well-regarded different theoretical viewpoints to social capital. One considers it as a collective resource that increases the coherence and functionality of the community, and the other views it as the resources of the individual actor to operate in the society. The former draws on the work of Robert Putnam, and the latter by Pierre Bourdieu (Siisiäinen, 2003, p. 204-205). Both viewpoints can be taken as a fruitful starting point when analyzing what positive resources the social networks of pubs can give to people.

In the heart of Putnam's definition of social capital lies general trust that is produced as trust between people in micro-level interactions such as those in the communities around pubs. Interactions with mutual trust create a virtuous or rosy circle of trust than enhances the coherence of community. The more social capital is spent the more it reproduces itself. The legitimatization of modern societies is also based on general trust in Putnam's theory. (Ibid., p. 204-206.) But the circles can also become vicious as mistrust and breaking of shared norms enhance isolation and more mistrust. This has been the case in the stigmatizing relation of outsiders to the pubs in the suburbs (Sulkunen et al., 1985). The day shift of the pub itself has broken shared norms of not drinking, but working during the day hours. This norm-breaking has created mistrust and isolation in the form of avoidance of these places by the outsiders who live in the same neighborhood. Putnam (2000, p. 22-24) coins the concepts of bonding and bridging social capital to analyze this phenomenon. Bonding social capital is inward looking and it reinforces homogenic groups. Regulars of a local pub during the day shift are typically a homogenous group in that they are masculine, they live in the same neighborhood, have similar kind of employment and economic situations, and are mostly of the same age. Bonding capital provides solidarity and social and psychological support. Bridging social capital is outward looking and encompasses people from different backgrounds creating links for people to external assets and information. Both bridging and bonding social capital can have powerful positive effects on people's

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lives. In the case of the day shift we can find strong examples of the bonding social capital supporting people in their everyday life through mutual support and help in a peer group. On the other hand we can see the lack of bridging social capital in the form of the prejudiced attitude of some people in the neighborhood.

Bourdieu focuses on the unequal positions of individuals in the society and the constant struggle on the different fields of society on which the actors battle with the resources they have acquired during the socialization processes they have gone through in the course of their life. His concept of habitus reflects these positions by combining the objective structures of the society and the subjectivity of the actors inside these structures. (Siisiäinen, 2003, p. 209) For Bourdieu social capital is one of the three assets that people rely on in when they operate in the different fields of the society, others being economic capital and cultural capital. Economic capital determines the class position and consists of the material resources the individual has access to. Cultural capital is internalized in the habitus in the form of skills and abilities and objectified as items and institutions. Social capital consists of the social resources that are depended of belonging to a specific group and knowing specific people. (Ibid., p. 209-211) This often also gains access to other types of capital in different fields. The interchangeability of the forms of capital in different fields is an integral part of Bourdieu's theory. Maintaining of the networks of social relations is based on actual practices that are necessary for the success on different fields of society (Siisiäinen, 2009, p. 209-210). Pubs and the institutions of the health care system are very different fields with different kind of frames for successful sets of capitals. From the point of view of someone who spends time in the pubs they serve as places for practices that do add up to social capital. They are places where you meet people, discuss issues, and exchange ideas and help.

Currently the social capital that pubs can offer people is bonding and inward looking and not constructing bridges between the pub and other fields of society. Could the social networks of the pubs have tools that could help people succeed in multiple fields of the society? In this project we set out to test how the bridge could be built between the pubs and the institutions of public health care. If a meaningful connection to health care serves as a starting point for a rosy circle it can lead to activity in encounters with multiple institutions of the society.

4.6 Trust in the social network – mistrust of the institutions

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“I come here for the karaoke every Wednesday. I even found my partner from the karaoke. We just love to sing. During the summer I just sit on the terrace here every now and then. It’s a good way of meeting people here. You can discuss about stuff.”

-One of the regular customers in a pub

Pubs serve as facilitators for encounters that lead to different kinds of relationships. People find new acquaintances, but also even married couples can be born in the pubs. People also help out each other and give advice to each other. The pub is a sort of collection of local expertise that you can utilize when you know what expertise people in the pubs possess. There are lots of experienced professionals in manual occupations and a lot of expertise regarding, for example, construction work and vehicles. Knowing people with the expertise makes them a trusted source from which to seek help when you need it - you know the people and they know their thing. Relying on public institutions is different from relying on real people you know. In the pubs you hear a lot of stories of bad experiences with public institutions. Often people only attend public health care or social services when they really have to because they just cannot take care of themselves anymore. Health centers are referred to as guessing centers because they never get the diagnoses right, they are just guessing. They just have doctors who don’t speak Finnish and seem incompetent and nurses preach at you about stupid things. The quality of their expertise cannot be trusted since you don’t know the people and you have heard of bad experiences.

In a research project Frykman and others discuss Putnam’s concepts of trust and social capital in the connections between local communities and the welfare state. They analyze how the trust, built from bottom down, effects health and wellbeing in the communities. Local communities adapt differently to the presence of the institutions of the welfare state. Community is based on the general trust in other people that live around. (Frykman et al., 2009 p.13.) In the pubs people trust the friends that they meet there regularly and rely on them as a great source of advice and help. Frykman and others use the concept of interactive rationality (Aumann & Dreze, 2005) to highlight that people do not maximize their utility automatically when they make decisions. Rather, ideas of how they will behave in a given situation are based on how they think others would act in similar situation. They act in accordance to the standards of solidarity. (Frykman et. al., 2009.)

For Frykman and others (ibid., p. 15-17) it is an asset to be regarded as a trustworthy person and it is also an asset to know people that one can trust. Social networks help people to find opportunities and

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improve the quality of life. Applying the concepts of bridging and bonding social capital, it is possible to define and differentiate open, and closed communities. In closed communities trust is particular to other members and not general. Open communities and organizations enhance trust between the members and the surrounding community. People have a lot of connections outside of the community and spaces of the community are open to access for the externals. Internal and external trusts are both important for the functioning of public services in the community. Currently the social networks in pubs are more closed than open communities, a sort of inverse refrigerators, communities that have cold relation to outside world. (Frykman et al., 2009 p. 39.)

Mistrust on the public institutions has led many people not to seek treatment for health problems until it is really needed, and sometimes too late, in the sense that starting treatment earlier would have made it much easier and lighter for the patient and for the personnel of the health care system. For example, in a very common case of arterial hypertension, just the diagnosis and the prescription for medication could make a great difference, even without any lifestyle changes or monitoring of diet. Without the medication and awareness of the condition, people suffering from arterial hypertension end up with symptoms that require heavy medical treatment in hospitals.

The men in the day shift don't see themselves as incapable of taking care of their own business. Even if they are pensioners they still have their freedom and capability of making their choices and doing what they wish to. Relying on the local community for help in different tasks is a traditional way of doing things in the Finnish countryside, that is how problems were solved before the great move, together with the men of the neighborhood. Keeping your life in your own hands is a strong ideal that seems to collide with the rationales of public health care institutions, but health expertise is not something that is easily found in the social network used as a source for solving other problems. Providing tools to deal with issues of health in these social networks could bring health care closer to the everyday life of the people, still protecting the important independency in relation to institutions.

To enhance general trust, the space of the community needs to be open. In the case of the pubs the space is open in practice, but the social threshold is high, especially due to the negative stereotypes of the day shift. Many people of the local community don't wish to attend the pub life and the world of public institutions remains far away. To build bridging social capital there is a need to lower the threshold and bring different worlds closer to each other. Bringing services of the health care to the space of pubs can give both; tools for taking care of health and supervising it independently, but also it can enhance trust towards the institutions of public health care. Based on the experiences of the

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pilot project, it at least generated a lot of positive experiences of the encounters with the institutions of public health care. As the mistrust is mainly based on stories of bad experiences, the positive experiences that are easy to access can have a great impact in lowering the threshold and creating the trust between people and institutions.

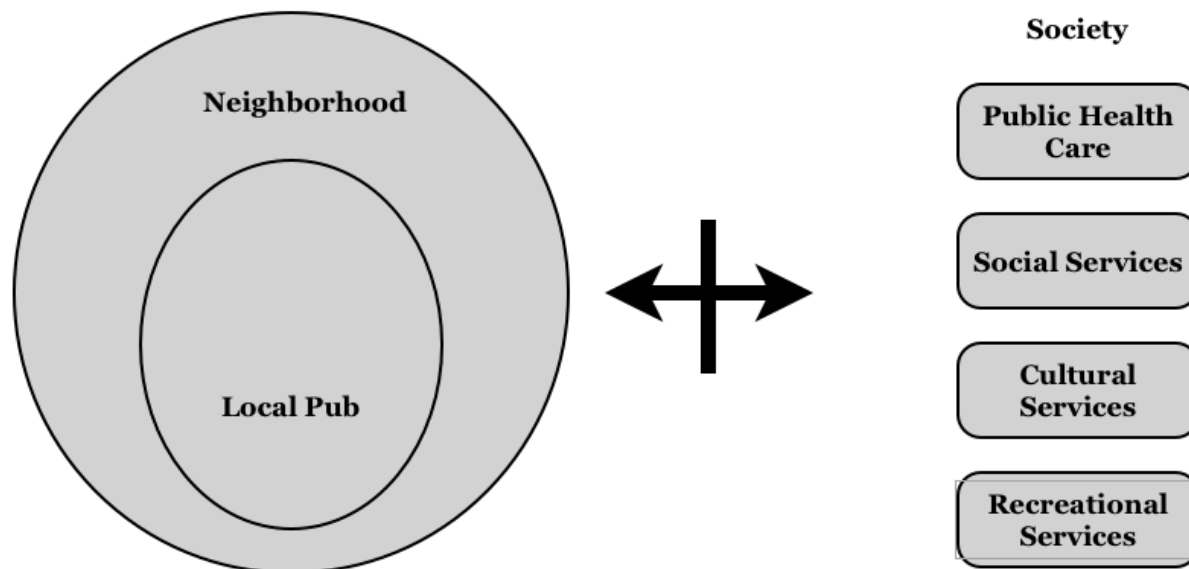


FIGURE 5. Besides the mistrust, the reachability of the services of society can be a challenge when they are not close. Currently the daily area of life for many people revolves around the pub and the surrounding neighborhood area, which can be geographically small.

4.7 Masculine Health as Capability and Functionality

“You know what effects the blood pressure most?”

-It’s the white jackets nurses wear. I’m so glad you are not wearing them. Now I will get a good score.”

-Comment from one of the customers to one of the students during the health visit

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In this section I will concentrate on the perceptions of health in relation to perceptions of being a man. As discussed earlier the conception of health is contested and socially negotiated. What health is to someone depends on their social position and relation to well being, body and official guidelines of health presented by the health care institutions. As wrong as it is to assume one fixed conception of health, it is also wrong to assume one fixed conception of masculinity. The pub is one specific social environment in which health and relation to body and health care are negotiated and come into being through mundane practices of everyday life.

Masculinity is about the characteristics or ways of being commonly considered to be typical for a man. Masculinity is a position in gender relations, a place which exists through practices men and women engage in, but also the effects these practices have on our bodily experiences, such as our feel of health, our personality and our culture. There are different internal logics at play within differently defined particular masculinities. (Connel 1995, p. 71-73) Prevailing ideas of being a man are referred to as hegemonic masculinity, but there are always other conflicting ideas that challenge the hegemony.

Hegemonic masculinity is always contestable and changes over time, taking different forms in different places. (Connel, 1995, p. 76) It is dynamic and open for change. Taking health care to the day shift is one possible way to contest some elements of hegemonic masculinity that affect the health behavior. As the home is traditionally a feminine space, the adventures outside of the sphere of home are a common part of masculinity and the pub is considered to be a masculine haven among all these adventures outside of home. (Frykman, 1996, p.16.) So, how is health perceived and acted out in the pubs among men?

“As long as there are battles to be fought, wars to be won, heights to be scaled, hard work to be done, some of us will have to “act like men”.” David Gilmore in *Manhood in the Making*

Gilmore (in Connel, 1995) draws together a summary of ethnographies from around the globe in order to find a deep universal structure of manhood and comes into a conclusion that the cultural function of masculine ideology is to get men to work. Ability to work and function autonomously is central for the manhood in the pub. You are healthy when you are able to engage in physical labor.

The perception of a working man with a functioning body as a tool is linked to working class labor. Paul Willis (1977) examined the production of an oppositional masculinity by young boys who grew

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up to become working class men by violating against the rules of the middle class school they were in by being the tough lads. The masculinity that the boys took up was not a way of being that was encouraged or even allowed by the school system. Masculinities that would be favored and encouraged by the health care system would probably be ways of being a man which would allow and welcome interventions in lifestyle and be open to current values and definitions of healthy lifestyle.

Public institutions are not able to produce and define one specific type of masculinity, as there will always be dialectical relations and opposition within the multiplicity of masculinities. Deciding and defining the ways of being that others shall take up is always going to be met by resistance.

What the public institutions perhaps could do is to remain accessible and open for multiplicity of masculinities and different ways of being a man.

4.8 Working Class Male Body as a Tool of Physical Labor

Gender is one of the other strong classifications being naturalized. Masculinity in the suburbs has strong historical working class roots. Suburbs were built for the working class and pubs quickly became gathering places for men who had move from the freedom of countryside farms to the suburbs and 8 to 4 industry occupations. (See for example Kortteinen, 1982, Sulkunen, Alasuutari, Nätkin & Kinnunen, 1985)

Resistance towards the rules of the school was the catalyst for the working class boys to join the masculine world of their fathers who worked in the physical labor professions. Resistance is an interesting aspect to view in regards to medical practice, which is based on generally accepted disciplining of human bodies. People are given advice to live in a way that is right for their body. You are supposed to be disciplined and obey the rules and advices in your everyday life regarding food, drinks and exercise. Obeying the rules is normal. People who do not obey the rules, who won't exercise and take care of their body or won't allow it to be taken care of with equipment and chemicals are considered to be undisciplined. They are actively violating the official guidelines of health behavior. This kind of behavior is often criticized and even calls for punishments on this kind of behavior are not uncommon. Typical examples are the demands for payments of the treatments of

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people who have caused themselves illnesses by smoking or eating unhealthy, the kind of behavior seen as typical of pub life.

As Michel Foucault has pointed out, in medical science and medical practices bodies are disciplined through making them objects that can be scrutinized and analyzed, which makes them objects which the practitioners can have knowledge of, and, through treatments, power over by molding and shaping them (Foucault, 1994). Medical practitioners also give advices to individuals to manage their own bodies. As Turner puts it bodies are objects over which we labor (Connel, 1995). Keeping up health is in many cases a clear material form of this labor. Eating, sleeping, washing and exercising are all forms of disciplining our own bodies. People who refuse to take up these forms of labor are undisciplined because they break against norm of how you should labor over your body. Taking care of your own body is a middle class idea of self-improvement. The gaze of others and the surveillance of doctors are to assure the quality of this labor. Working class labor implies the body as a concrete tool of the labor, which is conducted under surveillance. Free time is thus considered to be free from manual labor and the surveillance.

Fioretos (2009) follows Foucault's view that the social definition of what is normal and what is abnormal, right or wrong, affect our views on individuals. Moral aspects are entangled in the ideal of the body and its conduct. The body becomes a field mirroring the society's common views on what the body is and should be, and how people relate to their bodies and the bodies of others. This creates a culturally produced gaze on the body, which affects on how people are categorized for example in public health care. The trajectory of the working class male body is the trajectory of a body for labor. Appropriately, some of the men we discussed with described their bodies as a working glove. The female body on the other hand is the one that has become the field of constant reflection over how it feels through excessive education of women's magazine, TV-shows and currently also blogs. The conception of the male body is also changing in media and different kinds of ideals are being produced which challenge the perception of the male body as above all a tool of productive physical labor. Class and gender are cultural classifications ascribed to human bodies. Power works by making these power relations ascribed to bodies appear as seemingly natural and normal. Class is made in the process of classifications that differentiate people. (Skeggs, 2004) Health inequalities are a clear sign of the differences between socio-economic groups and genders in Finland.

4.9 Health Care in the Masculine Space of the Neighborhood Pub

Society and gender relations have changed a lot around the neighborhood pub since the times when suburbs were built and the large number of young people moved there from the countryside. The pub still remains as a place where men are allowed to be men and play by their own rules despite the changes in surrounding institutions of society and family. It is a space for traditional masculine adventure outside the feminine sphere of home and care (Frykman, 1996).

The pub is a space in which men are not patronized by the society, a place where you are free to be yourself whether it is in conflict with some behavioral norms or not. As long as you let others have their freedom, you will have yours. Pubs are associated with freedom also because they are places that serve alcohol. Alcohol is a traditional means of acquiring freedom, especially for the working class men in Finland. (Alasuutari, 1986) Regulars feel at home in the pubs, which are often referred to as second living rooms.

During the day shift, pubs are also meeting places for many retired men who feel themselves too young for the organized activities of the retired. Average time spent in retirement is rising and people who are retired more often have decades of active life ahead of them instead of a few tired years. Active recently retired men rarely feel they have much in common with the actual elderly grannies taking part in the organized activities of the retired. They don't want to go to the day care of the old folks where somebody is looking after them and organizing activities like bingo. They would rather get together in a space where they can still steer their own life. The same men who feel at home in the pub do not enjoy the events organized by authorities or organizations because they may also be full of new rules from the organizers and are hard to comprehend.

Spaces you encounter when dealing with the health care institutions are very different to the pubs. The world of health care institutions is a world run by women. Most of the personnel are women and they treat people as patients that need to be taken care of efficiently and objectively. When you enter a health care institution you need to play by the rules, wait in the waiting rooms, enter the examining rooms when your surname is called, obey the strict timetables and explain your problems within the 15 minutes appointments. People have official roles signified and enhanced by occupation titles,

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white coats and medical gear like stoscopes. Masculinity in the pub, and the way men perceive each other there is very different to how they feel being perceived as they enter the female - and rule regulated territory of the health care institutions.

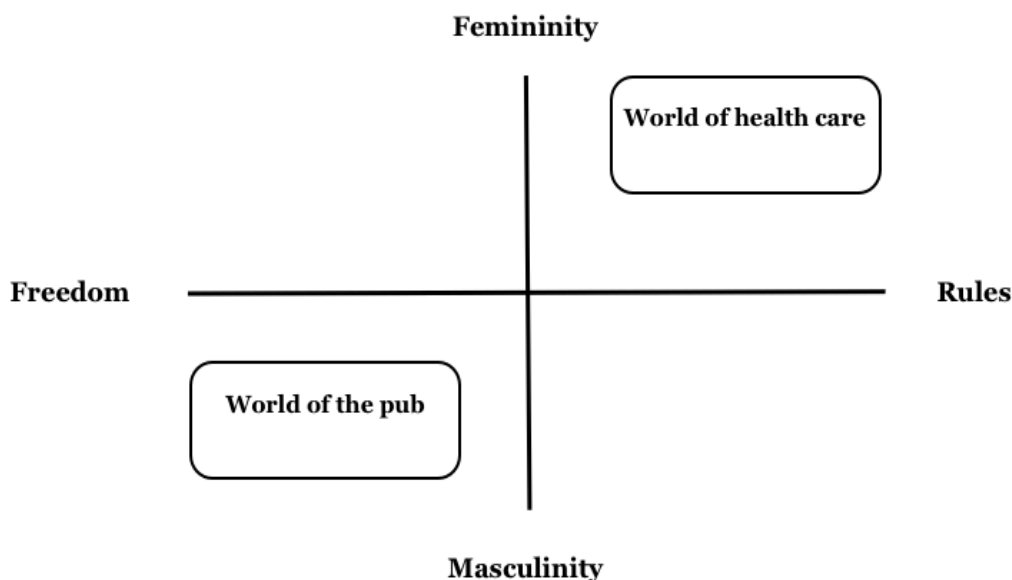


FIGURE 6. Two worlds displayed on a four-field.

The challenge in piloting this kind of service is how feminine and rules-guided health care can reach men of the pubs in their own terms, so that the service is meaningful and beneficial for the users. Health care as a premise is a field of hierarchical roles of doctors and nurses giving normative advice on how people should live their lives. This makes it challenging to produce a health service in the pubs, not intrusively, but easily accessible. Trying to do this was the aim of the health service pilot. Pubs were to serve as spaces for public health care to reach people in, spaces utilized as tools to further the interest of the public health care. This could have potentially resulted in a collision between conflicting interests in the use of the same space. Thus it was important not to disable any other activities in the pub, treating the pub guests with disrespect.

This was important for both the customers and the personnel of the pubs. It is not in the interest of the pubs that their good customers might leave the premises. A finding in the initial research conducted by Gemic was that one of the main challenges for the use of public health care is its physical location outside the routes of everyday life. A lot of the customers in the pubs do not move around much. They live in the same suburb in which the pub is located, and in general they get

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everything they need in that same neighborhood. Services not part of the daily routine and not on the daily route easily end up not even being considered. That is why, in the pubs, you can often hear discussions in which people apply their knowledge and expertise on helping out each other in various challenges of life. The health visit aimed to give tools for the existing networks of informal expertise, advice and help.

In bridging the gap between public health care services and the everyday life at the pubs the service had to be produced by listening to the concerns and wishes people had. This is one of the main reasons why service was taken to the pub and on regular hours every second Tuesday. That is how it would become part of the weekly routines like karaoke or any other weekly program organized in the pubs.

To not just invade the space, the service also had to respect the norms and ideals people have in the pubs. Pubs being places in which people come to drink and from which a lot of people go outside to smoke, advice on these matters should be left out of the scope of the service. The approach to all encounters was customer-centric. The starting point was very open; measurements of blood sugar and pressure served as openings for any discussions on health. Health was considered as a category to be negotiated from the position of the customer.

Negotiation is an important aspect of respect and trust. For Sennett (2003), equality cannot be just based on understanding of the others, but on autonomy that requires us to accept that which we don't understand in the others. If we consider this from the perspective of the public health care we need to ask how could health care approve of behavior that doesn't make sense from the perspective of health? In order to reach more people public health care institutions could reflect upon how to remain accessible and open for multiplicity of masculinities with different conceptions of health.

5. Piecing Together the Two Worlds in Health Visit Pilot

In this section I analyze the course of the health visit pilot based on my participant observation, group discussions with the health care students, informal discussions with customers and bar staff and the media attention the project received. The service concept of the health visit is very simple. Two students attend the pub at a given hour and set up blood sugar and blood pressure measurement tools on a corner table of the pub. Service is free and open for anyone and you get your scores on the

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spot. Measurements are not as reliable as they would be in the facilities of the health center and especially in case someone has been eating or drinking alcohol before the measurements. The professionals of the local health center chose these simple measurements as the idea was for them to serve as an icebreaker for further discussions. When you sit down for the time that the measurements take, it gives an opportunity to raise other topics of interest and ask anything that comes to your mind.

Based on the experiences of the pilot project we wrote a manual about the best practices in organizing a health visit in the pubs. There had been interest towards the project and we have presented the case in multiple seminars. During the project the media was also interested in it, as it seemed like an unexpected or even odd pairing of completely different rationales, which it actually was not. Health is an aspect and a pre-requisite of good life and in the same way as ideals of life differ, so do the conceptions of health.



PICTURE 4. Corner table in a local neighborhood pub in Helsinki in Autumn 2011.

5.1 Entering the world of pubs

Traditional ethnographies begin with an entrance story that constructs the setting for the endeavors and adventures of the researcher and the respondents. In this case the initial research was conducted before I entered the project. I went back to discuss with people, staff and the customers at approximately ten of the pubs that were field sites of the initial research. The goal was to find places that would be suitable for some kind of experiment with the promotion of health. I discussed with the bartenders and customers in order to find out what would be of interest and whether they thought it would be possible to organize something in the pub. The idea of some kind of a health visit quickly proved out to be interesting for the customers and bartenders. For the pilot we tried to involve pubs that had some kind of weekly time structure in the form of karaoke or a quiz night for example and a decent amount of customers coming in during the daytime.

Davies (2008, 78-79) remarks how in ethnographic projects you often need to choose your informants and sites based on the accessibility. You also need to work for the access. I took a long time to think about the potential benefits of the project from the perspective of the pub, the customers of the pubs, staff and the owners. After discussing with the staff and some customers and considering that I had possibly found a good place for the pilot I would contact the owner of the pub in order to seek access for the project. Most of the owners were immigrants and it proved to be difficult to get them on board in a municipal project. Health itself did not seem to be the issue, but rather the public institutions of municipality being involved got them hesitant.

Two pubs we took the pilot to were immediately on board and saw the shared interests instead of some clash between what they are selling and what public health care is doing. They saw it as a great possibility that could bring along positive attention and increase the popularity of the pub. What the customers and the staff did repeatedly stress was that the service should be something regular and not a one-time happening. Otherwise it would have no effect what so ever. If it was going to be in a set time in a given place people would learn the existence of the possibility and they could remember when it is and arrive at those hours.

Many of the students told me that before entering the pubs they were worried of how they would be met and afterwards they explained how their experience broke down prejudices. The staff at the bar proved out to be the most important allies for the students as they entered the pubs. People behind the

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bar helped to welcome the newcomers and explained to the regular customers who they were. Students took a table in the corner and set their gear, tools for measurement and a small sign on the tabletop. Many of the students stressed the importance of the staff. Bartenders served as gate openers and they were the ones who had the situation under control at all times. "The staff was very helpful. They showed us a good table and gave us some coffee and coke while we were chatting with the customers. They also actively encouraged people to come and measure their blood sugar and pressure. They also came to measure theirs."

It was not just the bartenders, but also the customers who were friendly and welcoming. "I was a bit nervous about how we would be welcomed by people, since this is not the most typical working environment for a nurse, but people were really friendly and interested in what we are doing. Everyone wanted to talk with us." This was a very typical comment that the students had afterwards. They had been a bit nervous or excited before the visit, but afterwards they felt positively surprised.

5.2 Sharing of Information about the Health Visit and within the Health Visit

One of the major challenges of organizing the pilot was the sharing of information. Firstly, sharing the information with people who could potentially attend the pub for the health visit proved to be difficult. People who happened to attend the pub during the visit always got the information from the bartender, but people who could have come either that or the other day were harder to reach with the information of the service. We made a notification poster that was put up in the pubs, but most customers didn't pay much notice to it or remember the date it mentioned even if they were interested. In one of the pubs, the advertising of the service was not so crucial, since the place was filled with customers anyway, in the other one we made more effort to inform the people living in the area. We got a permission to put up similar notifications on some of the apartment blocks near the pub. This brought in also some people who were not regular customers of the pub, but were really happy to have a chance for free measurements and positively surprised that it was possible at the pub. Later on the Healthy Neighborhood program promoted the health service by giving a press release and after that information was spread widely through multiple medias, but quickly after this the project came to its end. One of the arguments why many people we discussed with mentioned

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that the service should be regular was that people would learn and grow into the possibility of utilizing the health service on given days.

Terveysvierailu [redacted]

Tule mittauttamaan verenpaine- ja verensokeriarvot, sekä keskustelemaan terveysasioista [redacted] joka toinen tiistai alkaen 27.9. klo. 13-15. Muut päivät: 11.10. 25.10. ja 8.11. klo. 13-15.

Ammattikorkeakoulu Metropolian sairaanhoidon opiskelijat ovat kaikkien tavattavissa ravintolassa osana Helsingin Terveyskeskuksen Terveellinen kaupunginosa-ohjelmaa.

Tervetuloa!

Health visit at the pub.

Come and measure blood sugar and pressure.

Times and dates.

Organisers.

Terveellinen kaupunginosa
www.terveellinenkaupunginosa.fi

Helsingin kaupunki
Terveyskeskus

Metropolia

PICTURE 5. Information sheets that were posted on the wall of the pubs and shared out in the neighborhood had basic information about the health visit.

Word of mouth was a very important way of sharing news about the service and also during the visits. Bartenders served as important mediators between the health care and the customers by advertising the service, letting people know when it was going to take place and what was it all about. Information was also shared during the service as the students told about the measurements they were taking, answered people's questions and discussed with them. In all the interaction the framing of the sharing of information was considered as important. It was always about a possibility to take two simple measurements, the approach was to be non-judgmental and lifestyle choices were

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not to be criticized. Medical reliability of the measurements was not important since the main idea was to create a simple and positive experience of an encounter with public health care.

Some people criticized the fact that measuring of blood sugar or blood pressure should not be done when people have been drinking alcohol or eating, since the scores are not going to be accurate. This was mentioned to the customers who also asked about it. The idea for these measurements came from the health care professionals who considered these measurements as important for health promotion, since if someone is following two scores regarding their health blood pressure and blood sugar are good choices. There are a lot of people unaware of their problems with blood pressure or diabetes 2. Even the measurements are not reliable they still serve as an indicator of the actual levels and a starting point for discussions.

Scores of the measurements were given to people on a simple Post it –paper piece. These small and colorful pieces of paper proved to become important in the health service. The piece of paper was a concrete physical take-away and a memory from the encounter with the representatives of health care. It was a note about your scores, which helped to reflect back on the measurements, comparing the scores to healthy levels and the scores of friends. Pieces of paper also proved to have potential as a reminder. Reminding of the positive encounter with a health care professional and also as a reminder in a sense of an information tool that you can look back on after setting your goals for improving your health. Knowledge and awareness do not automatically result into changes of behavior, but positive experiences, physical reminders and milestones set up possible paths for behavioral change.

It is difficult to assess how many of the encounters in the health visit pilot resulted in change towards healthier lifestyle or new encounters with health care institutions in the health centers. There was no tracking of peoples further contacts with health care, in order to protect anonymity and also because it would have demanded a cumbersome process of securing research permits. Neither was there a book-keeping of the measurements since the measurements were not reliable in the first place and the main aim was to generate positive encounters and experiences. What we know for sure is that there were a lot of high measurements and many people were interested in further examinations of health care professionals and got a wake up call. On other hand a lot of people were relieved to find out their state of health was not as bad as they had feared for long.

5.3 Turning Social Capital into Tangible Solutions

“Did you take the tests? What were your scores?”

“What are the maximum levels one can get?”

–Typical comparison and discussion about the scores

People in the day shift value their freedom and capability of taking care of their own business. Health is a prerequisite for this kind of functionality, but proactive care in the form of healthy lifestyle choices is not allowed to restrict the freedom. Restrictions on what to eat and drink and when to exercise are decreasing the range of free capability. The challenge for the health visit pilot was to bring health into the social sphere of the pubs in a meaningful way without the customers experiencing a loss of self-control.

Retaining self-control in this case doesn't mean that people would insist on doing everything by themselves or being self-sufficient in some way and it doesn't mean that people would deny help. As mentioned earlier in the chapter about pubs as a source of social capital; they are places with social networks that support people in their everyday life. They are places for bonding, coming together and discussing all areas of life. As places for gathering and discussion, they do play a role in reducing the suffering from loneliness for many. They are also places where people seek knowledge and help from each other and share it between each other. Cooperation in the pubs is a similar form as the traditional way of doing things in the countryside where men would help other men in all tasks when needed. The form of mutual help that exists can be utilized in solving problems related to vehicles and construction for example, but the health expertise is harder to acquire from the social networks around pubs. How could health expertise become part of the knowledge menu available in the pubs?

Students who entered the pubs felt that it would be possible to build trust by getting to know everyone if they would have a chance to visit the same place regularly over longer periods of time. Health visits could provide a possibility to discuss and monitor one's condition in the form of regular health support. For the nurse it would also be easier to proceed deeper into discussions with the customers and help customers find a way of life in which they would feel they are well.

Health is always about negotiations and compromises between our goals and desires. You don't have to eat right or exercise all the time. As the nursing students mentioned it is ok to have a pizza and a

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beer every now and then. Health is never black and white. It is about balancing and finding your own golden mean, the middle way. These negotiations are always social in nature, even if they would only take place inside our heads. We compare ourselves to people around us, to the ideals we see and we evaluate our choices in relation to others. We can also discuss them, and even if we do not, things we hear and see affect our thinking. At best the visit can make the role of health visible in a way that is positive and interesting for the customers.

The post-it notes of blood sugar and blood pressure measurements served as a starting point for many discussions with comparisons and reasoning over different possible causes of the scores. The scores not being reliable also sparked an interest to know the right and true scores. During the two hours of health visit people could also easily come many times back and forth to the students to ask new questions that arise during their own discussions in other tables. The presence of the students was a refreshing variation from the daily routines and it actually made health issues the main topic of the day, and a topic that was also discussed between the visits.

Internal trust in the community allowed people to share and discuss scores and ideas of health together. In traditional health care institutions privacy is considered as important, appointments are behind closed doors and people come alone, or with a family member. The corner table of a pub has very low privacy, but this didn't seem to make people feel vulnerable or ashamed, which has something to do with the fact that they were not patients. Measurements were open in public, but they were not operations made on sick and vulnerable persons who have to trust their bodies in the hands of people who know better what is good for them. The visit was a possibility to get interesting knowledge of yourself, whether you felt you might have some issues regarding your health or not.

At best, health visit encounters between customers and nursing students were able to build bridging social capital (Putnam, 2000, p. 22-24). People who said they have not been to public health care for over 15 years because of their bad experiences now had a positive experience with the nurses, who actually came and offered a service without asking, and who were genuinely interested in discussing with you. After discussions with the students many customers mentioned they would actually go and visit the health center in order to get more correct measurements and perhaps discuss with a doctor. As we didn't track people, it is impossible to say how many actually did use the health visit as a first step of getting back into the health care system, but this was discussed and the students felt they were

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able to get a connection with the customers in a way that would also serve their future interest in encounters with the public health care. During the health visits, people who would not have visited the pubs otherwise also visited pubs. People walking their dogs would pass by and get their blood pressure measured even though they had not visited the neighborhood pub in ages. Health visits can thus serve as way of bringing different kinds of people together by lowering the threshold between the local community and the pub.

5.4 Shifting the Roles of Health Care through Health Visits

“It was way more relaxed than our work usually, it felt more like chatting with some friends.”

-One of the nursing students

Public health care institutions are based on fixed roles and hierarchies, like any public institutions. They are organizations, which are constructed of hierarchical impersonal roles defined by clear rules. Weber (1992) calls these organizations bureaucracies. In Weberian bureaucracies people are expected to leave out all of their personal aspects. They are to take on an organizational role with a clearly defined and strictly regulated given set of duties, but emotions and personal attachment are baggage for a rationally functioning organization. The role of a nurse contains an interesting contradiction in that when you take the white coat on emotions are to be left out, not to interfere the professional judgment. On the other hand, the nursing vocation is based on providing for the emotional needs of care and sympathy. Students mentioned that when they enter hospitals and health care centers for internships they are taught to retain professional distance from patients.

People have different possibilities to move around in the spaces of public health care. Some are allowed to enter all places at all times. Some are expected to wait in one space until they are called into another one. Different spaces in our everyday lives are staged differently and we take up different kinds of roles in those spaces. (Goffman, 1990) Clothing is one way of signifying the roles: white coats, health sandals, and stethoscopes around necks signal the professionals of health care. Professionals move with confidence and knowledge. Patients are outsiders who only visit the space restricted by the rules that professionals apply to them. Health care imposes expectations on patients.

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Fioretos (2009, p. 37) describes the ideal patient of the health care professionals. An ideal patient has good language skills and basic knowledge of health. They have attended the right place in the system of public health care and they restrict their visit to the symptoms they came for. They are able to communicate with professionals by giving them needed information, understanding the information they receive and acting upon it. They get the treatment and go back to their lives. Problematic patients don't know what is wrong with them and they keep on coming back for all kinds of issues.

How were the roles of professionals and patients shifted in the health visit project? Students felt that the lack of white uniform made them easier to contact. "It felt like people felt us easy to approach. We were more on the same level than usually." Clothing does stage the situation in different ways and, as one of the customers mentioned, "Now there is no effect from the white-coat syndrome that raises the blood pressure, so I get the right scores. Hah." Nursing students just identified themselves by a small sign and the equipment they had placed on the table. These served as the necessary cue of what is going and the equipment also evoked a lot of interest among the customers who wished to know how the equipment works. Discussions that emanated from the equipment often moved on to health considerations.

Difference in the use of time and space are also clear in comparison to health center for example. In the health visit, it is the nurses who are visiting the space of others. Health care has initiated the first contact by coming to people, not the other way around, which is the case when people call, reserve a time and attend appointments. When people are in their own space they are allowed to move freely, they know what they can and cannot do since it is they that inhabit the space. Health care providers visit the place at set hours, but during those hours all customers can come and go, as they will. They can come to the pub to spend time like any other day and while doing that, on the side, they can utilize the health service. There are no timetables, and during the health visit hours a lot of people came back to ask more and have another encounter with the students. In traditional health care appointment you need to solve everything in the given time slot and if you wish to come back to confirm or ask something, you need to book another appointment. Many of the people using the service also became regulars. They thought it was an easy and interesting way to keep track of their health condition.

The feeling of being on the same level with the customers was captured by a student describing how the two hours of the health visit had felt more like discussing with friends who were interested in health issues and asking a lot of questions about relevant and irrelevant things. As highlighted earlier,

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the health differences between different socio-economic groups and genders have been growing in Finland despite the political attempts to lower them. Encounters in the health visit are rare and interesting also because they are often between middle-aged men of the statistically worst health position and young educated females with the statistically best health position. Gender plays also an important role and many of the men were just delighted to get attention from young, bright women. These types of encounters between people of different genders and generations who otherwise probably would not interact much can be enriching for all involved. Many students were positively surprised by how friendly people were towards them, how much they actually knew beforehand and how good questions they had. “This broke a lot of stereotypes I had. In a positive way,” as one of the students said.

There is also a difference in the logic of the health service. In traditional health care service people who are sick decide they need help and they contact the professionals of health care. As discussed before this is not easy for men who consider that this would mean that they would be not functioning men who are fully in working order. During the health visit, the starting point was not that someone in the pubs would necessarily be sick. The use of the service was based on the interest to gain knowledge about own health. Customers were not treated as patients, but as curious fellow people. As mentioned before, the social aspect of the logic in the health service also shifted. People were not alone in the foreign terrain of the health care institutions, rather they were with their group of friends at their own place. They discussed health together and through these discussions a new kind of discourse of health can possibly emerge within their social network. When health is discussed and reasoned together people are more likely to revise their habits than when they face health care information alone. Caretaking already exists in the social networks in the pubs. If somebody is drinking too much friends will often interfere and discuss what is wrong. Limits are set together and friends are not left alone. Health care visit can offer practical tools for this caretaking in a form of new knowledge and enhanced motivation through the new encounters.

5.5 Summing the Main Differences between Traditional Public Health Care and the Health Visit Pilot

What in the health visit is new and different compared to traditional methods of health care that and what could be learned from that? First of all, we need to be clear about differences regarding the aim

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of the service and the logic of it. Health centers deal with patients and aim to effectively heal the symptoms that the patients have. The health visit pilot was a health promotion project aiming to help level the health inequalities by giving people tools to improve their health before they become patients. Despite the preventive nature of health visit there is a common feature of a real-life encounter between a professional of health care and a layman, which is often lacking from health promotion campaigns that are in a form of brochure, posters or media campaigns.

Encountering people instead of symptoms resulted in a more holistic view according to the students who conducted the health visit. They had more time to discuss all kinds of issues people brought up instead of focusing on the immediate care of a specific symptom. The encounter was not between two individuals, which is often the case in typical appointments in health centers. Two nursing students attending the pubs could be met either by an individual person or a group of people at the same time. Even if people came one by one, the social context was strongly present as others were in the same space and not in a separate waiting room. Also the immediate discussions with friends made results and health considerations social. Lack of privacy would probably be a problem in clinical consultations on sensitive issues, but in an open health promotion encounter it didn't seem to matter much. Some issues that could have been discussed one-to-one were left out, but on the other hand a social aspect was gained, which is important regarding the potential changing of habits and the changing of attitudes towards health care. Changing of habits is much easier in public with social support.

The following table sums up the main differences. Health care service was moved to a new place and a very different kind of space than the usual sterile spaces of health care institutions. Information of what is healthy wasn't just passed to people, but health was rather negotiated in relation to information nursing students could give. Interaction was more social and open for going and coming back to discuss other issues. Health care was the proactive actor in the sense of serving a possibility to enter the health visit, usually initiative for the encounter has to come from the patient.

	Traditional Health Care	Health Visit
Places	Centers in fixed locations	Mobile, possible to attend

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		different places
Spaces	Clinical sterile spaces designated to health care	Spaces of everyday life such as a pub
Concept of health	Defined from above	Negotiated together
Activity	Taking care of the sick	Giving tools to maintain health and prevent sickness
Interaction	Private: doctor/nurse-patient	Social: customer-service providers and friends
Time	Fixed meeting time	Open meeting time
Encounter	Based on the initiative of the sick person, but in terms of the institution	Based on the possibility given to an interested person

FIGURE 7. Main differences between the traditional health care setting and the health visit.

6. Findings and Discussion

This project was part of an innovation program that was set up to find new approaches in tackling the challenge of health inequalities. The approach of cultural analysis enables the dissection of health inequalities by viewing them through the differing perceptions of health in the various everyday contexts. The day shift of the pubs was chosen as an arena through which to get an access to masculine cultural forms that tend to clash with the practices and culture of the public health care institutions. A large share of the regular customers are middle-aged men who belong to the risk group of common national diseases, arterial hypertension and type-2 diabetes.

Ethnographic research was used as a tool in designing the health service together with the professionals of health care. The project was also a multidisciplinary empirical experiment. The experiment confirmed the idea that it is possible to offer health services in pubs if they are produced in cooperation with, and by listening to the needs and wishes of the customers. Health inequalities are an aggregate consisting of a variety of actual everyday practices in different fields of life and this project shows how it could be beneficial to view health inequalities through specific spaces or subcultures instead of just viewing the large-scale challenge as a whole. Whether this kind of service has strong potential in leveling the health inequalities is hard to measure based on a small pilot, but the experiences gathered in the pilot proved out to be positive.

6.1 Peculiar Change in the Context of Health Care

One of the main rationales of the Healthy Neighborhood program was the lowering of the thresholds of public health care services. The idea was to bring services closer to people by gaining insights into everyday life and introduce health promotion into everyday spaces. Through the pilot we could get a view on what the shift in the context meant for the customers and for the professionals of health care. Experiments were conducted in multiple places from libraries to shopping mall, but still the pub seemed to be perceived as the most surprising context for health care services by many. Taking health care to the day shift in the pubs received a significant amount of media attention. We were in the national morning radio with one of pub owners for a discussion, national television joined one of

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the health visits to interview people on TV news and multiple newspapers covered the project. It proved out be interesting material for the media and for the readers. Discussion chains below the Internet coverage where long and thousands of people shared the story in social media. The picture below gives a typical indication of how the project was presented in media. Beer and the daily tabloid in the hands of a man were chosen to contrast the traditional images of health care with nurses in their white coats.

The screenshot shows a news article on the YLE Helsinki website. The article title is "Terveyspalveluita tarjolla korttelibaareissa Itä-Helsingissä". The text of the article discusses a pilot project in neighborhood pubs, contrasting the traditional image of health care with a more relaxed setting like a pub. The article mentions that the service is intended for people who drink alcohol and have high blood pressure and sugar levels. The article is dated 2.11.2011 and published at 11:03 AM. The image shows a person's hands holding a glass of beer and a newspaper, symbolizing the contrast between traditional health care and the new service.

PICTURE 6. Finnish Public Broadcasting wrote about the project in their online news.

The main point of the media coverage was that we were doing something new and unexpected and the service was not meant to patronize or preach about the harms of alcohol, but to give a new type of light health service in the pubs. There were also debates about measuring the people who were drunk since the scores would not be reliable. Then there were plenty of negative comments towards the health care system and some of them ended with a positive remark on this project, such as

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“finally they are leaving their desks and entering the world.” Public health care services were considered to be of poor quality and doctors as puppets of the medical industry. Many of the debaters on the other hand thought the project was a great idea and hoped to see similar kind of services in their neighborhood also.

The change in the context didn't just inspire and surprise the media, but also the customers and the nursing students. Most customers were surprised in a positive way and they felt they were getting attention that inspired them to think of their health. Young women entering the pub and being interested of the middle aged men and their health made some customers even feel flattered and you could hear comments such as “Nobody has been interested in my health for years. This is great. I'll do whatever you tell me to.” At their best the encounters of the health service served as what a well-known Finnish philosopher Pekka Himanen has coined enriching interaction between actors of different backgrounds. It needs to be based on emotionally meaningful face-to-face encounters, which then later on makes it possible to retain and improve the relationship also through other means and in other places. (Himanen, 2010 p. 81-82.)

Students were positively surprised by the open attitude, interest and the amount of prior knowledge of the customers. Most of them felt that entering the context of the customer was a good experience in becoming a better nurse. Typically you only treat symptoms in the busy environment of the hospital or health center, but now they had time to discuss with people who were not there for the specific symptom to meet them, but because they were interested in learning and discussing. Students felt that this way they were able to get a more holistic encounter combining the mental and physical issues in discussions. Some felt that these kinds of encounters could be more effective than the ones you have in the institutions of health care. They started thinking about the possibility to develop a company around the idea of mobile health care unit, if they could have a team of nurses and doctor and a health bus they could take health care into multiple places. It doesn't have to be just located in a one given space.

6.2 Ethical Reflections on the Project

One of the main challenges in the project was in taking the approach of cultural analysis to the field of public health care, which is traditionally a field of medical scientific approach. Medical science and other natural sciences take an objective position outside of the studied phenomenon. In cultural

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analysis we do not have the privilege of viewing the social world from outside, we are always part of it. Differences to natural science also translate to important differences in considerations regarding the ethics of the research.

Medical science carries the problematic historical baggage of mistreatments and misuses of patients. Medical science, doctors and nurses, as its practitioners are the ones on whose hands we trust our lives on. They are the ones whom people go to receive help when most vulnerable, sick and weak. Because of the issue of trust and the historical baggage medical research is very restricted, guided by rules and supervised by different authorities both on national and international level. Ethical procedures are strict, especially when the research infringes human bodies.

In Finland medical scientific research projects are supervised by medical scientific research ethics committees consisting of experienced medical scientists and a few laymen representing the ones being researched. In the heart of the ethical conduct of medical research lies informed consent. Being a research object always needs to be based on voluntary decision, which is made after having received detailed and understandable information in written form. Researchers responsible for the project need to have all consent agreements as written contracts. Voluntary participation also entails that participation may be abandoned at any given time for no specific reason. All procedures that are part of the research need to be well reasoned. Also all possible benefits and harms of the research need to be weighted. (TUKIJA, 2012.)

Regulations and practices that are applicable in hospitals or laboratories can be very difficult or impossible to apply in practice in the field. When you study a group of people by observing them in public should you ask for their consent individually beforehand? That might often not be possible. (Thrift, 2003, p. 117-118) It is also difficult to say what does informed mean in contexts that you don't know the outcome of the research. I made sure to discuss the possible outcomes of the project in as much detail as possible with the owners and personnel of the pubs who served as gate-openers to social sphere of the pubs. Utilitarian reflections that are part of ethical practices of medical science also become difficult when you start viewing them from perspective of all stakeholders. It was hard to have clear expectations on how it would affect different actors when you take health care in to the pubs, but it was very important that all actors involved had a positive will to try this out.

Thrift (*ibid.*, p. 115-119) views ethics committees and codes of research ethics as a part of the rising audit culture in which ethical scrutiny becomes a professionalized field of its own. He warns about

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moving this bio-ethical apparatus to the field of social sciences. Committees attempt to render the ethical outcomes of research encounters predictable. You should be able to know what comes out of them beforehand and this is typically not possible in ethnographic research. Ethical considerations are not predictable and should not be made as an exercise beforehand, but occur in the process, in the demeanor of the researcher. One of the good values of ethnography is the possibility of relatively unpredictable encounters with unpredictable outcomes.

Thrift (2003) follows Spinoza in shifting ethical responsibility away from simple declarations of praise and blame to understanding it as an integral part of the process of constantly moving imagination which transforms all of us. Thus we have ethical responsibility over the process of change that expands the subjectivity of others and ours. In ethnographic fieldwork this means that we stress the importance of the encounters. Positive encounters are the ones in which imagination is exercised between people creating something new. In this way, encounters can bring insights to all parties involved. (Ibid., p. 113-114.) Productive and insight-rich encounters were the main goal of the health visit pilot and it did bring new ways of thinking to actors of different stakeholders on all sides of the table, not just for the people as potential customers, who started thinking about health and health care in a new way.

The problem of ethical committees and handbooks is that they take the responsibility away from the researcher by creating a separate sphere of normative audit. They give clear answers but often more important is the reflection process itself. Spinozan direction implies the cultivation of good judgment in the course of the research, in all encounters. (Ibid., p. 119.) Research is always an intervention to the world and all who are involved can and do affect each other (ibid., p. 122). In the case of health visit we also have an actual intervention by an institution to a space of another institution. What is the ethical consideration behind offering health services by taking them to people who could even be reluctant of encountering them, and forcing them to encounter the services in their own space?

Sulkunen (1997) reviews different ethical stances behind possible alcohol policies and we can apply these ethical stances to the health visit. Typical rationale behind Scandinavian alcohol policy has been that for the “public good” individuals can make sacrifices in their freedom. Moderate drinkers can make sacrifices in order to serve those at risk by higher prices and restricted availability for example. Public good refers to the rationale of the utility of the society as a whole, but we don’t need to sacrifice the freedom of individual. A Rawlsian stance considers the notion of “good life” as a private matter that shouldn’t be restricted or governed by the state. (Ibid., p. 119.) At the heart of the health visit pilot service lie the negotiation and voluntariness. Measurements serve as a starting

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point for discussions of what features regarding health are a part of an individual ideal of good life and it is possible to receive guidance on how these could be achieved. This can open up new possibilities and result in the expanding of subjectivity through change of thought in the encounter in a Spinozan sense. (Thrift 2003, p. 113-114.)

Sulkunen sees the current logic of health promotion as basing on a consequentialist principle that is neutralized of normativity by focusing on risks related to lifestyle choices. Public health promotion works by empowering people through giving them abilities to make choices that promote their own health. According to this view public health policies do not set norms on what is healthy life, but merely inform citizens who in the end have the responsibility over their choices. The problem of this kind of empowerment is that it assumes people are able and willing to make rational decisions. Normativity is vaguely hidden behind the neutralized façade of information about consequences. (Ibid., p. 1119-1121.)

For Sulkunen (1997, p. 1119-1122) the main problem of the consequentialist principle is that it is contractual of nature, but since the normativity is hidden the contract is more of an illusion of a contract. He suggests that rationalist consequentialist ethics should be couple with Durkheimian thought on ethical decisions belonging to the social sphere in which community is maintained. This implies that they are emotional and ritualistic not rational and contractual. This is not to say they could not also be rational. He sees as a possible application that public groups with clear moralities and goals could be supported in their health promotion work. I believe that one implication could also actually be that important health decision could be taken into the social sphere of shared rituals and emotions that bind people to each other in their relation. Currently the decisions and process of reflecting over health is between individual and the authorities giving official, neutral information. During the health visit we saw people gathering to discuss health together and to face health care, not in privacy, but together with people they are emotionally connected to in their everyday life.

Relationships to and among the informants being in the core of the process of ethical demeanor, I aimed to follow a few important principles of ethnographic research. First of all, I informed everyone I spoke with of the fact that I'm acting in the role of a researcher and I tried to explain what I'm trying to find out, but of course I could never be fully aware of the coming procedures in the process of the analysis. A doctor knows exactly what she is going to measure, in a blood sample, for example, and she can inform us in detail of what is going to happen next. Ethnographers can never

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fully know beforehand how the words and activities performed in real life will be analyzed in the process. Analysis is always open to new emerging issues.

Another traditional ethical code of the ethnographic research that I followed was to give anonymity to informants. I don't point out names of the pubs or give any information based on which my informants could be personified. Sometimes ethnographers use pseudonyms when they wish to give out a story of a specific respondent without revealing their identity. I don't give clear examples like these, partially because I wasn't able to inform all my informants that I would also use the data gathered during the research in my thesis, which is technically another research project. On the other hand, for this research descriptions of the pubs and discussions in them on a general level are sufficient to illustrate the phenomenon. Anonymisation of the two pubs in which the health visit took place would probably not be necessary since they appeared in all Finnish media, but my research is also based on observations and discussions in other pubs.

A third important aspect I realized over the course of the project is the semantics. It is often an arbitrary definition whether to consider a place as a bar, pub or a restaurant. Media represented most stories by coining the places as bars and illustrating this with beer pints. This reflected an attitude that did not do justice to some of the places, whose owners who had built their restaurant around the idea of serving tasty and honest food with a variety of drinks and differentiating their place from bars that only sell cheap beer. To apply an overall description that would do justice for the variety of the places visited during the research I decided call them pubs, which captures the local nature of the places and the possibility of serving both drinks and food.

6.3 Critical Views on the Project

In the media discussion some debaters felt this kind of project was a waste of time and resources since people who spend their time in the pubs should not be pampered, but get the same treatment as others. "If the health care goes to them, they will never learn to go to health care." It was also considered as people's own fault if they don't take care of their health. "Society should not waste resources on trying to help people who are doing harm to themselves and sitting in the pubs all days long." This is an interesting view that comes to both the morality and rationale of the welfare state. Should we interfere in people's lives? If someone is living an unhealthy life should we even take care of him or her? Regarding health promotion addressing type-2 diabetes and arterial hypertension, this

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comes down to the discussion of when and whether to interfere or not. Untreated cases may result in early death, but typically after expensive publicly funded treatments. Should we then just leave people to die on their own or try to engage with the patients at earlier stages of the disease? Even without any lifestyle changes, discovering and starting the treatment of arterial hypertension can make the life of the patient and the people around them much better and save costs for the public health care system.

Some of the debaters were unhappy with the pubs being presented in such a positive light because they strongly related to them as places affiliated with alcoholism and the alcohol problems of themselves and their friends. On the other hand, drinking somewhere else was considered even worse than drinking in the pub, as “you are not totally excluded if you are drinking here. It is not going well for the ones who are drinking in the woods.” The negative reputation of the suburban neighborhood pubs does have a historical trajectory behind it, but the social capital drawn from the pubs does, as we have seen, have multiple positive effects on people’s lives. Pubs and nightclubs also contrast their business in relation to reckless home-drinking, parties, and disturbances. Spokespeople from the businesses highlight the safe and supervised space of the controlled serving of alcohol. Health care services offer a concrete possibility for the businesses to present their responsible attitude towards safe and healthy ways of serving alcohol.

One problem of tackling health inequalities through service-development projects is the project form itself. This project has been described as an example of user-centric service design in multiple forums, but the large-scale problem of health inequalities remains. Projects as a form of public government have been viewed critically. Flexible, temporary organizations of business life do not necessarily suit the long-term goals of public institutions. Innovation projects can end up becoming substitutes for other mechanisms of health promotion, which are needed since the primary operation is under-resourced. Projects do not easily convert into long-term practices that would actually develop public institutions and it is extremely difficult to measure the impact of a project. (Rantala & Sulkunen, 2006.)

Jensen (2007) analyzes how the context of the project sets research into relation with different stakeholders that pose different expectations towards the research. He questions the idea of interest-free research through an example of an applied research project that aimed to be useful for different stakeholders. The concept of usefulness turned out to be rather a multiplicity of differing notions of usefulness that the research inevitably interferes with. Researchers always step into a field filled with

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pre-existing relations and practices, where political, economic, and scientific actors are already operating. The health visit was actually an explicit intervention into ecologies of both practices of the pubs and public health care. In the classic setting, the role of science is to speak the truth to the governing power. Statistics make the world more manageable and practical for government. Lack of numbers proved to be problematic for the health visit pilot. It proved to be very difficult to justify further development of the service without any solid quantitative data on the impacts of the service. It would have been interesting for the governing body of the public healthcare system to track whether the service actually functioned as an entry to health center and, if people did attend health care services afterwards, what were their exact measurement and what kind of treatment did they get.

The project form itself was also a challenge for the health visit pilot. A longer period for the pilot and more varied and in-depth research could have also produced an even better understanding of how the service could actually serve the people best. As Jensen (2007, p. 247) points out, it is certainly not the role of the researcher to decide whether a useful intervention has taken place. It is completely in the hands of the later users. Information that is valued in applied health care research is typically neutral and well standardized. If best practice guidelines and policy recommendations are seen as the sole benchmarks of the usefulness, nuance is rarely valued. Jensen urges us not to forget nuances; it is crucial that we can do something else than just speak simplified truth to the governing power.

In the beginning I discussed the risk of perceiving the users of public health care as customers and how it frames the relation as a market relation, which may lead to individual responsibility being masked as a freedom of choice. I believe the main value the health service can provide people is the possibility for further care. Lack of connections with health care leads to a lack of possibilities of care and possibilities of discovering needs for care. Mol (2008) contrasts the market logic with the logic of care. Logic of care doesn't begin from what people know or want, but what they need. Care is a process with no clear boundaries, thus differing from the logic of markets in which transaction is well defined and customer is to know exactly what they get from the provider. Caring is a matter of respecting and nourishing unexpectedly functioning mortal bodies.

Respecting others and their bodies is the challenging aspect of care. One of the main problems is the projecting of self on to the other. It is important to acknowledge the differences between people. Downplaying the difference only generates a false feeling of sympathy and prevents the actual negotiation. (Sennett, 2003) This applies also to differences in the perceptions on what health stands for among different groups.

6.4 Future Possibilities

I started with the aim to discover whether ethnographic understanding can be applied in the development of new health services that would contribute to the leveling of health inequalities. Health care in Finland is closely connected to the everyday institutions such as schools and workplaces. When more and more people are outside of the traditional 8 to 4 institutions there is a need for alternative meeting platforms between people and health care. In this project the pub was chosen as the alternative everyday institutions through which to study the possibilities of generating positive encounters between public health care and middle-aged men with health risks and rare care encounters.

Pubs proved to be potential sites for fruitful encounters that have potential in lowering the threshold between public health care and passive users of it. There can also be other interesting possibilities of taking health care out into the world. Sub-projects of the Healthy Neighborhood program also included a retail clinic that served similar kind of services as health visit, but in a large shopping mall in Eastern Helsinki. There was also a mobile dentist unit constructed in an old bus. Health care can come to people and not just in the form of health promotion campaigns but also as actual on-going care and treatments.

Cultural analysis could also open up new ways to understand encounters between other public services and their different customer groups. Many of the customers and bartenders in the pubs already had ideas for potential new pilots to try out: “These places are full of people who treat their broken heart with alcohol. Next you should really send here the psychology students. It would be a challenge for them.” Tackling latent mental problems could be a challenge of its own and health inequalities can still be viewed through multiple different spaces, practices and sub-cultures, but there is an interest for spreading the care and getting new tools for informal care in the social networks. Considering the promotion of public health it could be an interesting idea to tap into this interest.

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Lecture:

Damsholt, Tine in Copenhagen Feb. 8. 2011.