James Durston, Anna Paajanen

Nursing of Refugee and Asylum Seeker Families: An Integrative Review

Helsinki Metropolia University of Applied Sciences

Degree Programme in Nursing

SN13S1

Thesis

18.04.2016

Helsinki Metropolia University of Applied Sciences

Author(s) Title Number of Pages Date	James Durston, Anna Paajanen Nursing of Refugee and Asylum Seeker Families: An Integrative Review 30 pages 18 April 2016
Degree	Bachelor of Health Care
Degree Programme	Degree Programme in Nursing
Specialisation option	Nursing
Instructor(s)	Pirjo Koski, Lecturer

During recent years there has been a dramatic increase worldwide in the number of individuals seeking asylum. As a result of this mass migration, nurses will need more guidance on how to work with refugees and asylum seeker families in a variety of health care settings. The purpose of this thesis was to describe firstly the most common mental and physical health problems of refugees and asylum seekers, and secondly culturally competent nursing practices to work with this vulnerable group.

This thesis carried out an integrative literature review on nine articles selected from the CINAHL and PubMed databases. Data analysis was conducted using a general inductive approach.

Data was initially divided into two main themes on the basis of the two research questions and then categorized into subthemes. The subcategories regarding health problems were: mental illness, somatic illness, gynecological needs, abuse and negative impacts on health. The subcategories regarding nursing practice were: commonly used and suggested nursing approaches; suggestions to improve communication and interpretation; recommended training for nurses; techniques to improve cultural competence in nurses; and working in supportive and multi-professional teams.

The results of this thesis can be used to improve nurses' knowledge of the challenges faced by refugee and asylum seeker families, as well as provide guidance on how to provide culturally competent nursing care to this group.

Keywords	cultural competence, asylum seekers, refugees, nursing

Tekijä(t) Otsikko Sivumäärä Aika	James Durston, Anna Paajanen Nursing of Refugee and Asylum Seeker Families: An Integrative Review 30 sivua 18 Huhtikuuta 2016
Tutkinto	Sairaanhoitaja AMK
Koulutusohjelma	Degree Programme in Nursing
Suuntautumisvaihtoehto	Sairaanhoitaja
Ohjaaja(t)	Pirjo Koski, Lehtori

Viime vuosien aikana turvapaikanhakijoiden määrä on lisääntynyt erittäin paljon. Massiivisesta muuttoliikkeestä johtuen sairaanhoitajat tarvitsevat lisää ohjausta työhönsä pakolais- ja turvapaikanhakijaperheiden kanssa. Tämän opinnäytetyön tarkoituksena oli kuvailla pakolaisten ja turvapaikanhakijoiden yleisimpiä psyykkisiä sekä fyysisiä terveysongelmia ja kulttuurillisesti päteviä sairaanhoidollisia käytäntöjä tähän joukkoon liittyen.

Opinnäytetyössä käytettiin soveltaen tutkimusmenetelmänä integroitua kirjallisuuskatsausta. Aineistoksi valittiin tiedon haun perusteella yhdeksän artikkelia CINAHL ja PudMed tietokannoista. Aineiston analyysi toteutettiin induktiivisesti.

Tulokset jaettiin kahteen pääteemaan tutkimuskysymysten perusteella ja tämän jälkeen luokiteltiin alakategorioihin. Terveysongelmiin liittyen alakategorioiksi muodostuivat: psyykkinen sairaus, somaattinen sairaus, gynekologiset tarpeet, pahoinpitely ja terveydelle haitalliset vaikutukset. Hoitotyön käytäntöihin liittyen alakategorioiksi muodostuivat: yleisimmin käytetyt ja ehdotetut sairaanhoidolliset menetelmät; ehdotukset koskien kommunikaation ja tulkkauksen parantamista; suositeltavia koulutusaiheita sairaanhoitajille; sairaanhoitajien kulttuurillista kompetenssia edistävät tekijät; ja työskentely kannustavissa sekä moniammatillisissa työyhteisössä.

Opinnäytetyön tuloksia voidaan käyttää edistämään sairaanhoitajien tietopohjaa pakolaisten ja turvapaikanhakijoiden kohtaamista vaikeuksista sekä ohjeistaa heitä kulttuurillisesti pätevässä hoitotyössä.

Avainsanat	kulttuurillinen pätevyys, turvapaikanhakijat, pakolaiset, sairaanhoito

Contents

1 Introduction

During recent years there has been a dramatic increase worldwide in the number of individuals displaced by war and persecution seeking asylum (UNHCR 2015:2). As a result of this mass migration, it is highly likely that nurses around the world will encounter refugees and asylum seeker families during their work. However, research indicates that nurses do not feel equipped to meet the unique needs of this vulnerable group (Hogg 2010:165). Challenges include the physical and mental health problems caused by war, migration and poverty as well as cultural and language differences (Hogg 2010:169; Kemp 2008:359; Taylor 2008:52). Therefore, in the coming years nurses will need more guidance on how to work with refugees and asylum seekers in a variety of health care settings.

The thesis addressed, firstly the most common mental and physical health problems of refugees and asylum seekers, and secondly culturally competent nursing practices to work with this vulnerable group. The mental and physical health status of refugees and asylum seekers appears to be a relatively well researched phenomenon, Hogg (2010) and Taylor (2008), for example have provided summaries of previous research. However, there appears to be a lack of studies focusing on refugee and asylum seeker families, and in particular a lack of evidence regarding culturally competent nursing practices that can be used to address the challenges highlighted by previous research.

The purpose of this thesis was to conduct an integrative literature review of nursing science literature concerning refugee and asylum seeker families in order to provide a comprehensive understanding of the topic. This purpose is in keeping with the method of an integrative review, which can be used to provide a holistic understanding of a concept or health care issue used to inform practice, policy and research (Coughlan et al. 2013:17; Whitmore and Knafl 2005:548). The emphasis in this thesis is on implications for practice. Additionally recommendations for further research are outlined.

1.1 Research Questions

1. What are the most common mental and physical health problems that refugee and asylum seeker families suffer from within the first few years after arrival in western countries?
2. What kinds of nursing practice have been identified in order to move to-wards culturally competent health care for refugee and asylum seeker families?

The thesis approached the research questions from the perspective of all nurses (sairaanhoitaja in Finnish) that encounter refugee and asylum seeker families in a wide range of health care settings such as hospitals, pediatric wards, mental health wards, health care centres or refugee reception centres. The thesis may be of benefit to other groups such as midwives (kätilö), public health nurses (terveydenhoitaja), practical nurses (läihihoitaja), nursing researchers, policy makers or other groups but they are not the focus of this thesis.

The thesis is part of intercultural midwifery and care research project and is carried out in cooperation with the Helsinki Metropolia University of Applied Sciences.

2 Definitions of Key Terms

This chapter defines the following terms (italics) as they are understood in the context of this thesis.

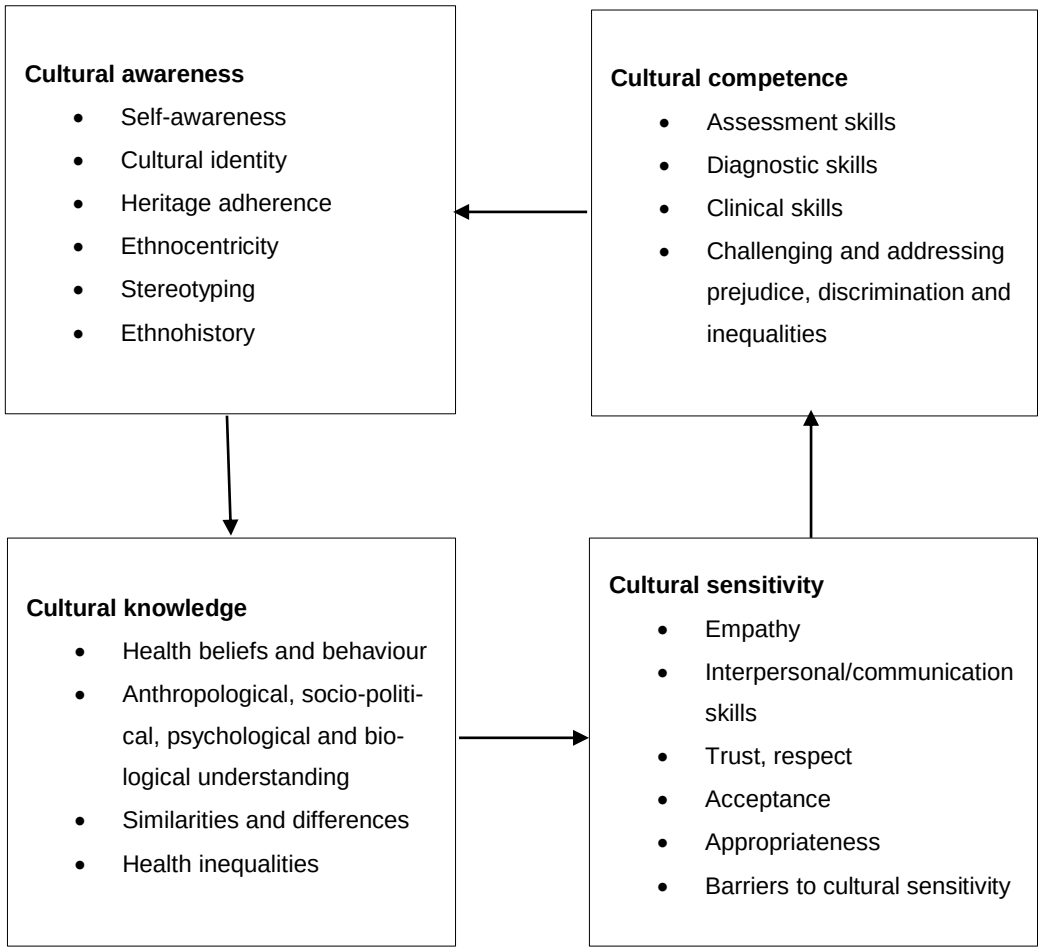
The 1951 Refugee Convention defines a *refugee* as someone who “owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former ha-bitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it” (United Nations, 1951).

Asylum is a human right recognized by the 1951 United Nations Convention. Countries are duty bound to grant individuals refuge if their claim for refugee status is supported by evidence. An individual is classified as an *asylum seeker* whilst waiting for a decision regarding their refugee status. (Hogg 2010:167.)

In the context of this thesis a *family* is defined as a group of more than one person including at least one child under the age of 18 and one parent. Relationships with extended family such as grandparents may be mentioned but are not the focus of the thesis.

For the purpose of this thesis *culturally competent care* is defined using the Papadopoulos, Tilki and Taylor model, first published in 1998, for developing cultural competence in nurses (Papadopoulos 2008:10).

The model defines cultural competence as the ability to provide people from different backgrounds with effective care whilst considering the way they behave, their beliefs and what their actual needs are (Papadopoulos 2008:10). Learning cultural competence is a lifelong process involving the constant development of skills and knowledge acquired through our professional and personal lives. The model gives structure to cultural competence and helps the learning process. The values in the model are derived from basic human rights, different sociopolitical systems, intercultural relations, ethics and caring (Papadopoulos 2008:10).



Picture 2.1. The Papadopoulos, Tilki and Taylor model for developing cultural competence (Papadopoulos 2006:10).

Cultural awareness includes examining an individual's own value base and beliefs which will guide their actions even if they are not aware of them. Anyone observing their values will notice that although they might share the same values as someone else, the interpretation of those values will most likely differ. Stereotyping is common and cultural assumptions are influenced by the norms of the culture and society that health care professionals live in. Gaining some basic knowledge about ethnohistory (history, geography, sociocultural background) of patients is important. (Papadopoulos 2008:11-13.)

Cultural knowledge can be gained from many practices such as anthropology, sociology, psychology, biology, nursing, medicine and arts. Understanding health inequalities and the reasons they occur is essential. Inequality occurs when certain groups do not have the same access to health care as others due to their income, education or ethnicity. (Papadopoulos 2008:13-16.)

Cultural sensitivity develops when there is a sense of partnership which includes trust, acceptance and respect. Sharing power with patients and facilitating empowering succeed through effective communication. Information such as patient education should be accessible through appropriate formats to everyone from different backgrounds. Furthermore a health care worker must understand that using family members (e.g. children) as interpreters is improper. (Papadopoulos 2008:16-18.)

Finally mastering cultural competence comes from mastering all three stages above. It is a combination of awareness, knowledge and sensitivity. A culturally competent nurse will recognize and challenge racism and make holistic assessments of situations and people. Furthermore health care workers should listen to how the patient perceives their problem, explain their own interpretation and understand the differences and similarities between these two views. When the views have been examined, recommendations can be made to the patient and a treatment plan can be negotiated. (Papadopoulos 2008:18-20.)

3 Previous Research

Nursing for refugees and asylum seekers appears to be a relatively well explored phenomenon. Hogg (2010), Taylor (2006) and Kemp (2008) among others have summarized research, including their own, specifically on the topic of nursing refugees and asylum seekers. Some of the key findings from these summaries are outlined in the following sections.

Previous research has focused on health inequalities related to the lower socio-economic status of minority and ethnic groups (Taylor 2008:52). However, there appears to be a lack of studies focusing on refugee and asylum seeker families, and in particular a lack of evidence regarding culturally competent nursing practices that can be used to address the challenges highlighted by previous research. For example, Hogg (2010:174) highlights a lack of evidence to assist with the process of working with refugees with mental health problems despite the challenges.

Nevertheless, health care systems around the world have made efforts to meet the unique needs of refugees and have provided guidance for health care personal. In Australia, for example, The Victorian Foundation for Survivors of Torture has published and regularly updated an impressively comprehensive "guide for doctors, nurses and other health care providers caring for people from refugee backgrounds" titled 'Promoting Refugee Health' (Foundation House 2012). In the UK there are a number of asylum seeker and refugee specialist nursing services, for example, Bolton NHS Foundation Trust (2015). A limited internet search revealed guidance for nurses in the NHS working with refugees and asylum seekers, for example The Leeds Teaching Hospitals (2015).

In Finland the National Institute for Health and Welfare (THL) has gathered information about asylum seekers' general health and supporting of their mental health. They have highlighted not only health problems but also health needs. Most asylum seekers coming to Finland are at a fertile age and hence sexual and reproductive health needs to be considered. (THL, 2015.) THL has also collected information through the Maamu study, which focuses on the health and wellbeing of migrants from Russian, Somali and Kurdish backgrounds in order to develop and evaluate the social and health care system. The National Institute for Health and Welfare found that refugees and asylum seekers in Finland have a great desire to work and consider themselves very healthy (Maamu 2011).

However, the Helsinki Diaconess Institute (2010) found that about one third of underage refugees and asylum seekers show symptoms of trauma.

3.1 Refugees and Asylum Seekers Worldwide

According to the UN Refugee agency (UNHCR 2015) an estimated 59.5 million individuals were displaced worldwide in 2014 due to persecution, conflict, violence and human rights violations. This figure includes 13.9 million newly displaced in 2014, with Syrian, Afghan and Somali refugees representing 53% of the total (UNHCR 2015:2). The 'nation of the displaced' refugees would be the 24th largest country ~~in the world if it was a country~~. In 2010 around 10,900 individuals per day globally left their homes due to persecution and war. By 2013 it had reached 23,400 and in 2014 it was 42,500 individuals per day. In 2014 a record 1.7 million individuals worldwide claimed asylum with Russia, Germany, the United States of America and Turkey being the most common destinations. (UNHCR 2015:2.) In Europe more than 219,000 refugees and migrants crossed the Mediterranean Sea during 2014, three times the previous high in 2011 and a figure that has almost certainly increased in 2015. In 2014 at least 3,500 men, women and children died while attempting the dangerous crossing. (UNHCR 2015:8.) Within the first three months of 2015 185 000 first time asylum seekers have sought refuge in the EU which is an 86 % increase on the same period in 2014 (Eurostat 2015).

3.2 Consequences for Health Care

3.2.1 Health Problems

The scale of the crisis highlighted by these figures will undoubtedly have consequences for the provision of health care globally and for nurses who will almost certainly come into contact with refugees or asylum seekers during their working careers. Hogg (2010:165) argues that "some health professionals may feel ill-equipped to deal with the complex medical and social needs of asylum seekers and refugees". Whilst there are some discrepancies among findings, previous studies broadly suggest that the health status of refugee and asylum seeker populations is lower than that of the indigenous populations with significant consequences for their way of life (Hogg 2010:170; Taylor 2008: 58). For example, Carrigan (2014:25) described how refugees and asylum seek-

ers families in Australia coming from countries such as Syria and Afghanistan, often suffered from conditions such as Post Traumatic Stress Disorder and vitamin D deficiency. Incidences of diseases such as HIV and TB were also of concern (Carrigan 2014:25).

On the other hand, refugees and asylum seekers have a lower average age than indigenous populations and are in that sense healthier (Taylor 2008:58; Hogg 2010:167). Mental health conditions such as stress, depression and anxiety are more common among refugees but it is important to remember that normal distress during war, for example, is not the same as mental pathology (Taylor 2008:58). Similarly Hogg (2010:173) points out that whilst mental health problems are common, a majority of refugees are able to withstand very difficult circumstances without mental illness and it is important not to label individuals without diagnosis.

Kemp (2008:358) highlights three phases of health and adjustment that refugees go through. The acute phase is the first phase and communicable diseases (e.g. tuberculosis, hepatitis B) are the main concern, but it is also a phase of hope and relief. The transition phase is when secondary chronic health problems and/or mental health problems arise. Finally, the resolution phase is hopefully characterized by health and other needs being met but may also include the inability to access health care and continuation of chronic illnesses. (Kemp 2008:358.) Similarly Taylor (2008:55) outlines the unique physical and mental consequences of the 'pre-flight, flight, reception, settlement and resettlement' stages and concludes that refugees often share health problems similar to others with low socio-economic status but have additional problems caused by the 'refugee experience'.

Asylum seekers and refugees might also come from countries with very little focus on illness prevention. Hogg (2010:170) explains that refugees in the UK are vulnerable to certain diseases because they have not had adequate vaccinations. In addition, significant numbers of refugees and asylum seekers may have been tortured and medical and nursing procedures could remind them of previous experiences (Hogg 2010:171).

3.2.2 Culture Shock

In addition to the health problems that migrants bring with them, the process of adjustment or assimilation in a new culture can be stressful. Migrants need to adjust to a new lifestyle including a new language, climate, customs and diet whilst at the same time

dealing with the isolation caused by leaving loved ones and friends behind (Hogg 2010:166). Refugees and asylum seekers also experience poverty and discrimination in their host country, they may be unable to work or access health care and may have lengthy periods of detention, all of which have negative impacts on health (Hogg 2010:173).

Refugees may be used to very different or traditional forms of health care and nurses will also need to help them adjust to western style health care systems, for example doctor prescriptions or referrals (Carrigan 2014:24). Carrigan (2014:27) describes how refugees in Australia are often diagnosed with conditions such as diabetes that they had no awareness of.

3.2.3 Cultural Barriers

Nurses working with patients from different cultures also face a number of barriers to providing high quality health care such as language and cultural differences. Use of interpreters can assist in overcoming language difficulties (Taylor 2008:61). Unsurprisingly previous studies indicate that patients can be more effectively screened and referred for further care when communication between nurse and patient is enhanced (Taylor 2008:61). Kemp (2008:362) highlights the benefits of community nursing run primarily by student nurses to detect and treat health problems in hard to reach and underserved populations with the ultimate goal that patients recognize themselves the need for health care and know how to make appointments. Migrants may be unaware what health services are available and have difficulties getting access due to communication problems (Taylor 2008:52). Hogg (2010:165) points out that despite usually being considered as one group, refugees and asylum seekers often have different needs, and that both groups can also come from a wide variety of places with very different life experiences. Taylor (2008:60) also emphasizes the importance of gaining specific cultural knowledge specific to particular cultural groups but nevertheless also treating all patients as individuals.

3.3 Refugee and Asylum Seeker Families with Children

Families and children make up a significant proportion of refugees and asylum seekers. In 2009 around 41 per cent of global refugees were children under 18 years of age, by

2014 it had increased to 51 per cent. For the first time, more than half of the people displaced by war and conflict worldwide are children. (UNHCR 2015: 2.) Children and young people are a very vulnerable group who may have been left traumatized and in poor health due to the situation in their home country, poor health care in their home country and/or due to difficulties of their escape (Hogg 2010: 178). Malnutrition, diseases and violence are common in refugee camps and some children may have been child soldiers in their home country (Hogg 2010:173). Trauma may present with somatic symptoms and children might suffer from headaches, muscle cramps and stomach aches with poor appetites also common (Saari, 2012:264). On a positive note children and young people are often able to adjust to the new culture quicker than their parents, although this may lead to tensions within the family (Hogg 2010:180). Women may be particularly vulnerable during pregnancy and childbirth as adverse circumstances may have prevented sufficient antenatal care or good nutrition (Hogg 2010:177). Hogg (2015:167) points out that many refugee 'families' in the UK are often missing one parent, for example, family members may be separated if members migrate in stages. This thesis focused on families as they make up a significant proportion of refugee and asylum seekers, and the health needs of individuals and the family are difficult to separate. The health of individuals in the family has a strong influence on the health of the family as a whole. Furthermore, the thesis is part of the intercultural midwifery and care research project which has the target to support the wellbeing and health of childbearing immigrant and ethnic women and their families.

3.4 Refugees and Asylum Seekers in Finland

In 2014 developing countries hosted 86% of the world's refugees, with around 25% of the global total being hosted by some of the world's least developed countries. Nevertheless, the movement of refugees will also have profound consequences for developed countries such as Finland. Nurses are highly likely to treat refugees or asylum seekers during their careers. In 2014 Sweden had 15 refugees for every 1,000 inhabitants (putting Sweden in the top 10 globally but far from the figures of 232 in Lebanon and 87 in Jordan respectively) (UNHCR 2014:15). In 2014 Finland had 11,798 refugees or individuals in refugees like situations, with 1,754 applications for asylum pending for comparison the UK figures were 117,161 and 36,383 respectively (UNHCR 2015:45). During 2014 3,651 individuals submitted applications for asylum in Finland of which 196 were under aged and arrived on their own. The numbers have risen quickly and within the first seven months of 2015 there have already been 4,121 applications for asylum of

which 305 are children who came to the country without their parents. Since 2001 Finland has taken 750 quota refugees every year but this was increased to 1050 in 2014 due to the situation in Syria. (Migri 2015.)

The reception centers in Finland offer asylum seekers free basic health care services or buy them from the private sector (Hoitopaikanvalinta 2015). The Finnish law states that an adult is entitled to urgent health care when needed and children are entitled to the same health care services as someone who has a home municipality in Finland (17.6.2011/746 §26; 30.12.2010/1326 §50; 1.12.1989/1062 §3). Vaccinations and screenings are voluntary apart from if tuberculosis is suspected. Asylum seekers are entitled to receive information about the social services and health care within the first fifteen days of arrival. Once refugee status has been granted refugees are entitled to use all public health care services. (Hoitopaikanvalinta 2015.)

4 Methodology

4.1 Method

An integrative literature review was conducted in this thesis. A literature review should include a critical evaluation of current knowledge, pointing out discrepancies and similarities and giving the reader a short, coherent and unbiased summary (Coughlan et al. 2013:2). An integrative review can be used to summarize both empirical and theoretical literature to provide more understanding about a problem in health care or phenomenon which can be used to inform practice (Whittemorer and Knaflk 2005:547). Integrative reviews are thought to be more systematic and rigorous than narrative reviews although it can be difficult to distinguish them from each other (Coughlan et al. 2013: 17). The advantage of an integrative review is that a wide range of qualitative, quantitative, mixed methodology or even theoretical literature can be included (Whittemorer and Knaflk 2005:547; Coughlan et al. 2013:17). An integrative review was selected for this thesis as it is a more realistic alternative to systematic reviews for inexperienced researchers and because the wide variety of sources permitted can be used to generate a more holistic understanding of the topic.

4.2 Database Searches

Thorough literature searching prevents incomplete searching and selection bias (Coughlan 2013:17). The search strategy was to do a database search using CINAHL and PubMed with the following keywords: "nursing", "asylum seeker"; "refugee" and "child". To get accurate results, we combined these words, using the Boolean operators OR and AND, as well as truncation marks as shown in Table 1. The strategy was to search for peer reviewed articles written in English from 2005 to October 2015 that had an abstract available.

In the database search 81 articles were found of which 41 were discarded based on a quick read of the title and abstract. Following careful reading of the 41 abstracts a further 30 articles were discarded and 11 were selected for full text review. Only primary sources were selected. Articles were also rejected if the abstract indicated that the research did not answer either of the research questions and/or research had been carried out in the developing world. Of the 11 articles one article was not available as a full text and one article was discarded as the focus was on immigrants in general rather than refugees/asylum seekers and was very specific to mental health nursing. Therefore 9 articles were selected for the final review of the literature. Articles selected include a variety of qualitative, quantitative and mixed-method approaches.

Database and other limits	Language	search date	search terms	number of hits	discarded based on title/abstract	Number reviewed (title and abstract)	Number reviewed full text
EBSCO (CINAHL) (2005-present, peer reviewed, abstract available)	English	6.10.2015	((refugee* OR "asylum seeker*") AND nursing) AND child*	18	4	14	4
PubMed (2005-present)	English	6.10.2015	((refugee* OR "asylum seeker*") AND nursing) AND child*	63	36	27	5

Table 8.1. Database search (based on Coughlan et al. 2013:91).

4.3 Data Analysis and Presentation of Results

Analysing and synthesising data from a wide range of sources is one of the biggest challenges of conducting an integrative review and well-defined research questions can assist with the process (Whittemorer and Knaflk 2005:548). The first stage of analysis in an integrative review is to divide sources into logical subgroups (Whittemorer and Knaflk 2005:549). In this thesis the sources were initially classified based on whether they were quantitative, qualitative or mixed methodology sources?

The use of a matrix (Table 9.1) makes it easier to systematically compare the primary sources (Whittemorer and Knaflk 2005:549). The next stage is to collect data from multiple sources into subgroups based on themes.

Data analysis was conducted by a process that Thomas (2003:2) describes as a general inductive approach. Even though this method is referred to as inductive, it actually uses a mixture of deductive and inductive elements (Thomas 2003:3). The first stage of data analysis is determined by the research objective. In this thesis data from the nine articles were organised into two main themes based on whether they answer research question one (health problems of refugees and asylum seeker families) or research question two (culturally competent nursing care for refugees and asylum seeker families) (Table 9.2). This is the deductive stage of data analysis as the research questions were derived from previous knowledge about the topic. Following stage one, the final subgroups under each theme were derived by a process of reading and rereading the data to find the most common and significant themes (Table 9.2). This is the inductive stage of data analysis. The general inductive approach has the advantages of summarising a large amount of varied data (Thomas 2003:2).

During the data analysis of an integrative review patterns, themes and relationships can be identified. Contrasts as well as comparisons should be highlighted. Finally, based on the analysis of each subgroup overall conclusions regarding the topic can be drawn. (Whittemore and Knaflk 2005:551.) Coughlan et al. (2013:90) outline a similar process of thematic analysis as described above and point out that it is the most common method used in a literature review undertaken at undergraduate level and also if the literature is from a mixture of research and non-research sources. Whilst a certain amount of interpretation is required, the process of thematic analysis mostly involves providing a summary of research. The idea is to bring together the most important and repeated themes

about the topic in the literature. (Coughlan et al. 2013:97.) Results of the thematic analysis are presented in Table 9.2.

4.4 Limitations of Research and Ethical Considerations

The authors received guidance on how to use Boolean operators and truncation marks in order for the database search to be reliable. Two different databases were used to get a wider selection of articles. It however is possible that significant research in the subject area was not included in either of the two databases. As the availability of abstracts and articles guided the selection process it is possible that significant articles will be left out. In an integrative review key publications should be included and great efforts should be made to avoid 'selection bias' but it does not need to review all available literature (Coughlan et al. 2013: 16). To avoid plagiarism the thesis will be checked using the Turnitin program throughout the project.

From an ethical perspective findings will have to be reported with complete honesty without misinformation, misrepresentation and/or misleading. Unintentional misinterpretation should also be considered and avoided. As other people's works are used in this thesis, appropriate credit needs to be given. (Logan University: Learning Resources Center, 2015.) Efforts will be made to ensure that the results of the thesis are both valid and reliable, in other words the method and subsequent analysis should be described and carried out in such a way that the process could be carried out by other researchers and that very similar conclusions would be drawn. According to Golafshani (2003:604) "Reliability and validity are conceptualized as trustworthiness, rigor and quality in qualitative paradigm." Triangulation is used to enhance reliability and validity in qualitative research. A literature review by its nature involves the process of triangulation because the idea is to find convergence between multiple sources of information, i.e. findings highlighted by this literature review can become more valid if it can be shown that different researchers using different methods have come to similar conclusions about the topic. (Golafshani 2003:604.)

5 Results

Nine articles in total: five qualitative, one quantitative and one mixed study as well as two case studies were included in the literature review. Table 9.1 provides an overview of each article including authors year, country of study, title, purpose, participants in study, method data collection and analysis and main findings, conclusions and recommendations. Every article contained data that could be used to answer both research questions to some extent. Organizing the data in Table 1 made it easier to compare and observe the findings and detect the most important and repeated themes in the data. Table 9.2 provides a summary of the main themes in the data. The findings were organized in Table 9.2 under two main themes driven by the research questions and subcategories were formed during the analysis based on the most important and repeated themes.

Table 9.1

Author(s), year, country of study, title	Purpose	Participants	Method, data collection and analysis	Main Findings	Conclusions and recommendations
Burchill (2011), UK Safeguarding vulnerable families: work with refugees and asylum seekers.	To describe the experiences of health visitors working with refugees and asylum seekers in London.	14 health visitors, purposive sampling.	In-depth interviews (conducted in 2006), transcribed and analysed using the Framework method.1	Health visitor experiences indicated that domestic violence, depression, child neglect, destitution and poverty were significant health problems in refugee families. Asylum seeking women and children were trapped in a cycle of abuse and disappearing from the system was common.	Practitioners need to raise concerns with managers. New ways of joint working to prevent difficulties of working with vulnerable group
Drennan et al. (2005), UK Health visiting and refugee families: issues in professional practice	To describe experiences of health visitors working with refugee families in London and investigate their perceptions of effective strategies to address the health needs of this group.	13 health visitors experienced working with refugee families (including 9 immigrants)	Individual semi-structured interviews. Analysis using the Framework method.	Health visitor experiences indicated that PTSD and depression were common among refugee mothers. Health visitors would prioritize the needs of children before women. They felt unprepared to address the needs of refugee families.	Strategies for working with refugees and asylum seekers such as taking extra time to explain services, use of community organizations and good practice using interpreters were highlighted, but were not developed and coordinated at an organizational level. Sharing of collective knowledge was recommended. Helping refugee families to access services was a key aim.
Tobin et al. (2014), Ireland Irish midwives' experiences of providing maternity care to non-Irish women seeking asylum	To gain an understanding of how midwives can be better equipped and supported to provide more effective care for asylum seeking women.	10 midwives, purposive sampling. 5 urban, 5 rural.	In-depth unstructured interviews. Content analysis	Five themes were identified: barriers to communication, understanding cultural difference, challenges of caring for women who were unbooked, the emotional cost of caring and structural barriers to effective care.	Authors concluded that findings highlight the need for focus on supporting to midwives to increase their cultural competence, better maternity services for immigrants and immediate policy changes.

Paris et al. (2006), USA A home-based intervention for immigrant and refugee trauma survivors	Case study to describe a home-visiting program targeting refugee and immigrant new mothers. The multilingual home-visitor 'paraprofessionals' were immigrants and mothers themselves.	105 first time mothers, average age 28 with three quarters under 30.	Qualitative case study description of home-visiting program.	Substance abuse, anxiety, depression, PTSD, trauma, child neglect and isolation were highlighted as health problems in refugee and immigrant families. The benefits of 'paraprofessionals' working as role models and advocates were highlighted. The value of screening and prioritizing high-risk families was discussed.	Author's argue that case study demonstrates the benefits of using well-trained and well-supervised 'paraprofessionals' who are also mothers and members of immigrant communities to work with refugee families with significant risk factors.
Kurth et al. (2010), Switzerland A reproductive health care for asylum-seeking women - A challenge for health professionals	Find out the reproductive health issues in young women seeking asylum in Switzerland and what kind of care they receive	80 women	Mixed method: semi-structured interviews with health care providers and quantitative descriptive data from patients' files. Quantitative data was analyzed descriptively and qualitative by Grounded Theory.	The abortion rate for asylum seekers was 2,5 times higher than for the local population. Health professionals reported language barriers and emotional challenges when taking care of asylum seekers.	Suggestions to improve care for asylum seekers included use of professional interpreters, support and training for health care personal and more focus on psychological care.
Springer et al. (2010), USA Somali Bantu Refugees in SW Idaho: Assessment Using Participatory Research	To assess the health needs of Somali Bantu refugees in SW Idaho using a cultural and community assessment.	12 members of Somali Bantu community, 5 health care providers and 5 volunteers.	Descriptive qualitative method using Community Based Participatory Research including formal and informal interviews. Interviews analysed by searching for similarities and themes.	Health problems encountered in the community included asthma, diabetes, high blood pressure, lack of vaccinations and obesity.	Findings suggested that the studied community had an increased risk for health disparities. Study highlights the benefits of increased screening and community nursing in vulnerable populations.

Bischoff et al. (2009) Switzerland Health and Ill health of asylum seekers in Switzerland	To find out the most common diseases amongst asylum seekers.	979 asylum seekers enrolled for Swiss Health Maintenance Organisation in 2000-2003.	Quantitative data from the Swiss Health Maintenance Organisation. Descriptive statistics were used to assess typical health problems and average numbers of health visits. Analysis was used to determine if age, gender or region of origin was significant in the results.	The most common health problems in asylum seekers were musculoskeletal diseases, respiratory diseases, depression and PTSD. One-fifth of the population did not request health care during the period.	Most common health conditions were chronic rather than communicable acute diseases suggesting that the focus of refugee health care should be on continuity of care rather than emergency acute care.
Kell et al. (2005), UK Collaboration in eczema care: a case study	To demonstrate the benefits of a collaborative approach between a refugee family, their GP, health visitor and interpreter to improve health.	One refugee boy	Case study	Community nursing, a collaborative and effective communication through interpretation lead to significantly improved health outcome for the boy and his family.	Authors argue that collaborative working leads to significant health benefits and makes more efficient use of limited resources.
Beatson, J. (2013), USA Supporting Refugee Somali Bantu Mothers with Children with Disabilities	To gain an understanding of how local Somali Bantu refugee mothers with children with disabilities perceive education or health needs of their children.	5 Somali Bantu mothers and 1 father	Grounded theory qualitative method. Semi structured, open-ended interviews. Analysed by coding and categorising into themes. Furthermore realist tales were included.	Indicated that study population is at high-risk of significant health problems.	Study highlighted the need for good communication with refugee families and better understanding of the refugee experience by nurses to improve health outcomes.

Table 9.2

Theme	
Common health problems in refugee and asylum seeker families	Culturally competent nursing of refugee and asylum seeker families
Mental illness • depression, PTSD, anxiety and trauma **Somatic illness** • chronic conditions such as hypertension and diabetes • musculoskeletal diseases such as lower back pain **Gynecological needs** • pregnancy and giving birth • unwanted pregnancy and abortion **Abuse** • sexual assault • domestic abuse • child neglect **Negative impacts on health** • poverty/destitution • isolation and loneliness • migratory stresses • use of traditional medicine (not in all cases) • non-compliance with treatment • lack of preventative health care e.g. immunizations	**Commonly used and suggested nursing approaches** • community nursing, home visitation and outreach • screening and prioritization of health problems • use of local community organizations • increased focus on sexual and mental health • long-term family centered approach **Suggestions to improve communication and interpretation** • extra time, clear and explicit instructions, use of pictures • careful and active listening • greater availability of interpretation including by phone • well-trained and health literate interpreters **Recommended training for nurses** • cultural training • helping patients with psychological trauma • social security and legal issues **Techniques to improve cultural competence in nurses** • ask about cultural background and incorporate into care plan • allowing alternative practices • avoiding stereotyping and assumptions about ethnicity • use of health care professionals with immigrant background **Working in supportive and multi-professional teams** • collaborative working • emotional and practical support for health care professionals • knowledge sharing

5.1 Common Health Problems in Refugee and Asylum Seeker Families

The data concerning the first research question, the common health problems in refugee and asylum seeker families were categorized under five different subthemes (Table 9.2): mental illness, somatic illness, gynecological needs, abuse, and risk factors.

Many articles discussed the different mental illnesses that asylum seeker and refugee families encountered such as depression, post-traumatic stress syndrome, anxiety and trauma (Burchill 2011:24; Drennan et al. 2005:159; Bischoff et al. 2009:60; Paris et al. 2006:39; Kurth 2010:4; Springer et al. 2010:7).

Somatic illnesses have been studied less than mental illnesses, however Bischoff et al. (2009:60) studied asylum seeker's health in Switzerland and reported that the most common health conditions were chronic rather than communicable acute diseases. Families from a refugee background were found to suffer from chronic conditions such as hypertension, diabetes and musculoskeletal diseases (Springer et al. 2010:7; Bischoff et al. 2009:60).

Furthermore Bischoff et al. (2009:61) and Kurth et al. (2010:5) mentioned the gynecological needs of female asylum seekers and refugees. This subtheme included pregnancy and giving birth as well as unwanted pregnancies and abortions (Bischoff et al. 2009:61; Kurth et al. 2010:4).

A few articles described different forms of abuse that occurred in many families and required health care. Nurses and midwives came across victims of sexual assault, domestic abuse and child neglect. (Burchill 2011:25; Paris et al. 2006:38; Kurth et al. 2010:4.)

Different negative impacts on health were discussed in many articles and hence the importance of attending to not only health problems, but also negative impacts leading to them was highlighted. Burchill (2011:25) mentioned that many asylum seekers were facing destitution which was partly due to isolation. Isolation as well as loneliness were reported in other articles too (Drennan et al. 2005:160; Paris et al. 2006:39). In addition many asylum seeker and refugee families suffered from migratory stresses (Drennan et al. 2005:160; Kurth et al. 2010:7). Moreover as the concept of preventative health care is totally new to many asylum seekers and refugees (Springer et al 2010:9) there is a

lack of preventative health care such as immunizations (Kell et al. 2005:31; Springer et al. 2010:2; Beatson 2013:144). Use of traditional medicines was also included under this subtheme although it is not a negative impact in all cases. (Spinger et al. 2010:6.) Other articles highlighted that refugees may not comply with treatment for example because they do not understand instructions (Kell et al. 2005:31). Individuals may be unwilling to comply with treatment if they receive conflicting advice from friends and family, for example regarding traditional medicines, or if family members are not involved in care (Spinger 2010:9).

5.2 Culturally Competent Nursing of Refugee and Asylum Seeker Families

Data obtained from the articles regarding the second research question, culturally competent nursing of refugee and asylum seeker families, were categorized under the following five subthemes (Table 9.2): commonly used and suggested nursing approaches; suggestions to improve communication and interpretation; recommended training for nurses; techniques to improve cultural competence in nurses; and working in supportive and multi-professional teams.

The benefits of using community nursing, home visitation and outreach nursing with refugee and asylum seeker families were well represented in the articles (Tobin et al. 2014:167; Paris et al. 2006:39; Springer et al. 2010:8; Kell et al. 2005:33). One benefit of this approach is that it allows nurses to screen for health risks in order to prevent them earlier. Subsequently screening and prioritizing of health risks was also highlighted (Paris et al. 2006:40; Springer 2010:8; Bischoff et al. 2009:63; Drennan et al. 2005:159). A number of articles mentioned the strengths of using local community organization's to support families in difficult circumstances and encourage peer support (Drennan et al. 2005:160; Paris et al. 2006:43; Kell et al. 2005:33). Findings in other articles suggested that mental health and sexual health were areas that are currently neglected and should be emphasized more when working with refugee and asylum seeker families (Kurth 2010:4 and 10; Paris at al. 2014:40; Bischoff et al. 2009:63). A number of articles also mentioned the benefits of fostering long-term relationships with families and of having a family centered approach (Kell at al. 2005:32; Drennan et al. 2005:161; Paris et al. 2006).

The challenges of communicating effectively with refugee and asylum seeker families was highlighted by articles. The importance of taking extra time to explain unfamiliar concepts such as preventative health care was commonly mentioned in the articles

(Drennan et al. 2005:159; Paris et al. 2006: 42; Kurth 2010:8; Beatson 2013:144; Springer at al. 2010:8). The benefits of clear and explicit instructions as well as the use of pictures was also highlighted (Tobin et al. 2014:166; Springer 2010:8; Kell 2005:33). Successful communication also included careful and active listening (Tobin et al. 2014:167; Paris et al. 2006:44). Increasing the availability and quality of interpretation through the use of well-trained and health literate interpreters was also of particular concern. (Drennan et al. 2005:159; Kurth et al. 2010:10; Springer et al. 2010:8; Kell et al. 2005:31; Beatson 2013:144; Tobin et al. 2014:?.)

Articles suggested that staff felt ill-equipped to deal with the difficult situations they encountered when working with refugee and asylum seeker families and therefore the importance of more training was highlighted. Cultural training, training to help patients suffering from psychological trauma and country-specific social security/legal issues were all mentioned. (Drennan 2005:161; Paris et al. 2006:44; Kurth 2010:10; Beatson 2013:142; Tobin et al. 2014:163.)

The benefits of actively asking patients about their cultural background and making efforts to incorporate their wishes into care plans were well represented in the articles (Drennan et al. 2005:159; Tobin et al. 2014:164; Paris et al. 2006:42; Beatson 2013:144). The importance of avoiding stereotyping and assumptions about ethnicity based on country of origin were also highlighted (Tobin et al. 2014:164; Springer et al. 2010:8). The advantages of using bi/multi-lingual health professionals with an immigrant background when working with refugee and asylum seeker families were mentioned by more than one article (Drennan et al. 2005:158, Paris et al. 2006:45, Kell et al. 2005:31). Allowing the use of alternative practices that do not conflict with treatment should also be incorporated into care (Tobin et al. 2014:164; Beatson 2013:144).

A number of articles referred to the complexity and emotionally draining effect of working with refugee and asylum seeker families (Burchill 2011:26; Kurth et al. 2010:7; Tobin et al. 2014:165). Using collaborative working in multi-professional teams was a reoccurring idea to combat this (Burchill 2011:26; Paris et al. 2006:43, Kell et al. 2005:30). Furthermore emotional support for nurses and other health care professionals was recommended (Tobin et al. 2014:165; Paris et al. 2006:40; Kurth 2010:7). Finally, sharing knowledge with colleagues was also put forward (Drennan et al. 2005:162).

6 Discussion

6.1 Common Health Problems in Refugee and Asylum Seeker Families

The most common health problems that refugee and asylum seeker families suffer from within the first few years after arrival in western countries are depression, PTSD, anxiety, trauma and chronic conditions such as hypertension, diabetes and musculoskeletal diseases (Burchill 2011:24; Drennan et al. 2005:159; Bischoff et al. 2009:60; Paris et al. 2006:39; Kurth 2010:4; Springer et al. 2010:7).

In the chosen articles mental health conditions in the asylum seeking population were more emphasized than physical health problems. Considering the terrors some have to survive prior to getting to the host country and the issues that they face upon arrival it seems only natural that mental health should be underlined. Kurth et al. (2010:5) reported psychosocial stress factors caused by traumatizing past events such as war and rape. Previous research by Hogg (2010:171) also mentioned the fact that refugees and asylum seekers might have been tortured in their country of origin and that medical procedures can remind them of previous experiences. Additionally the asylum seekers living situations in the host country can be extremely stressful due to living apart from their families and having fears concerning their future as they have no certainty of being granted asylum (Kurth et al. 2010:6). The depth of mental health problems was also emphasized by the following quote from a health visitor interviewed by Drennan et al.:

"I know it sounds terrible, but I generally work on the assumption that they're likely to have some element of depression anyway, because of their circumstances…"

(Drennan et al. 2005:160)

Bishchoff et al. (2009:61) found that among asylum seekers the prevalence of PTSD is high but communicable diseases are low. However previous research from Kemp (2008:358) highlighted that upon arrival the biggest concern are the communicable diseases, such as tuberculosis and hepatitis B. This contradicts with Bischoff et al. (2009:60) as they reveal that the most common physical health conditions were chronic rather than communicable acute diseases. According to this the emphasis should be on continuity of care rather than emergency acute care. This is worrying as in Finland the health care for adult asylum seekers only covers urgent health care (17.6.2011/746 §26; 30.12.2010/1326 §50; 1.12.1989/1062 §3).

Nonetheless Burchill (2011:24) describes the needs of refugees and asylum seekers as extremely complex and similarly Drennan et al. (2005:159) pointed out that the priorities in these very complex situations were to address the fundamental physiological and safety needs. However the Finnish National Institute for Health and Welfare (THL 2015) discussed not only the fact that asylum seekers and refugees have health problems but that they also have health needs. For instance THL (2015) mentioned the fact that as most asylum seekers are at a fertile age they also have sexual and reproductive health needs. This is accurate as Kurth et al. (2010:8) stated that asylum seeker's abortion rate is 2,5 higher than the local population's.

Hogg (2010:170) pointed out that asylum seekers and refugees might come from countries with very little focus on illness prevention. This is in line with the results of this thesis as the data obtained showed that there is a lack in preventative health care and health promotion. Furthermore the stressful and uncertain situation in life in the host country puts a risk on asylum seekers' health. Burchill (2011:25) discussed the effects of social isolation and poverty on parenting and the normal development of children. The health care workers interviewed by Drennan et al. (2005:160) all mentioned trying to address the isolation by informing refugee mothers about activities and community organizations. As it appears that isolation, loneliness and different forms of abuse are not uncommon in families with a refugee background, the information about integrating into the new country needs to be easily accessible.

6.2 Culturally Competent Nursing of Refugee and Asylum Seeker Families

This literature review set out to answer the question: What kinds of nursing practice have been identified in order to move towards culturally competent health care for refugee and asylum seeker families?

6.2.1 Commonly Used and Suggested Nursing Approaches

A number of articles pointed to the benefits of community nursing, home visits and outreach. According to Tobin et al. (2014:168) community-based services improve access, encourage continuity of care, and foster better client/provider relationships. Home visitors in the Visiting Moms Program described by Paris et al. (2006:39) provided friendship,

practical support and role modelling. These findings are consistent with previous research such as Kemp (2008:362), who argues that home visitation is an effective way to detect and treat health problems in communities that are underserved and difficult to reach. Also Taylor (2008:52) points out that many refugees are either unaware of the availability of health care services or may be unable to access services due to communication problems. By bringing services to them home visitation is one way to lower the threshold for refugee families to access health care. One criticism of this approach might be that it is resource intensive and may not be as applicable for all nursing as it is for midwifery. However the long-term costs of allowing conditions to progress to more serious stages should also be considered. Springer et al. (2010:8) found that visiting the emergency department only after becoming very sick was common in the refugee community studied, and argued that more public health visits were needed to increase awareness of conditions such as diabetes and hypertension. For Kell et al. (2005:33) health visitors have a major role in supporting disadvantaged and vulnerable groups.

Nurses working with refugees and asylum seekers need to screen and prioritise needs. To determine which mothers are in the greatest need of home visiting services the Visiting Moms Program described by Paris et al. (2006:40) assess factors such as isolation, depression and risk of abuse. Drennan (et al. 2005:159) found that health visitors working with asylum seeker families in temporary accommodation prioritised the health of children over the health of mothers. Health visitors tried to get as much information as possible before the family moves on (Drennan et al. 2005:160). Ideally nurses would have time to address all health needs, however a recurring phenomenon in the articles was that due to the complexity of needs, the difficulty of maintaining long-term relationships and a lack of resources the nurses had to prioritise basic needs. This approach is in line with the situation in many countries, including Finland which states that an asylum seeking adult is only entitled to urgent health care when needed (17.6.2011/746 §26; 30.12.2010/1326 §50; 1.12.1989/1062 §3).

Community organisations were used to reduce social isolation by all the health visitors interviewed (13) in the study by Drennan et al. (2005:160), and they often accompanied the women to first meetings. Similarly Paris et al. (2006:43) explains how health visitors successfully connected women to their local community by, for example, enrolling them in English classes. Kell et al. (2005:33) highlights that local women's groups are a way to educate refugee mothers about childhood health problems, but are also a way to find out health needs.

The high incidence of mental health needs reported in the articles is in line with previous research, e.g. Hogg (2010:173) and Taylor (2008:58), but nurses should bear in mind that a majority of refugees do not suffer from mental illness (Hogg 2010:173) and normal distress in difficult situations is not a mental pathology (Taylor 2008:58). Nevertheless results indicate that more focus on mental health is required in refugee populations. Bischoff et al. (2009:63) suggested that mental illness is under reported due to communication problems. In conclusion the study recommends promoting models of long-term care to better treat chronic illness, including mental illness (Bischoff et al. (200):63). Tobin et al. (2014:166) described how psychiatric counselling was not always available and for this reason midwives would avoid raising traumatic subjects with clients in some cases. As an example of good practice Paris et al. (2006:40) explains how health visitors in the Visiting Moms Program are trained how to identify the effects of trauma and how to respond.

In terms of sexual health Kurth et al. (2010:10) proposed making contraception available more easily without cost. THL points out that most asylum seekers coming to Finland are at a fertile age and sexual and reproductive health needs to be considered. Previous research such as Hogg (2010:177) noted similarly to Tobin et al. (2014:166) that women may be particularly vulnerable during pregnancy and childbirth as adverse circumstances may have prevented sufficient antenatal care or good nutrition.

The study by Drennan et al. (2005:160) highlighted the importance of long-term care relationships due to the emergence of trauma after several years of trust building. This fits with previous research, for example, in Kemp's (2008:358) three phases of health and adjustment for refugees, the second phase many years after arrival is when mental health problems typically arise. Bischoff et al. (2009:63) recommended long-term care models and Drennan et al. (2005:161) highlights the benefits of long-term interpreter relationships. In the Visiting Moms Program described by Paris et al. (2006:40) support was provided for up to three years. For Kell (2005:32) a long-term family centered approach means working in collaboration with the family and other professionals as equal partners increasing participation, empowerment and ultimately compliance with treatment.

6.2.2 Techniques to Improve Communication and Interpretation

Previous research indicated that refugees may not be familiar with particular aspects of western health care such as immunizations, chronic conditions and even that health services are available (Carrigan 2014:27; Taylor 2008:52). Similar observations were noted

in the literature review and therefore the importance taking extra time to explain concepts was emphasized. Springer et al. (2010:8) observed that there was significant risk for misunderstanding in the refugee community studied and terms such as inherited disease had little meaning for the refugees. Written instructions were not generally helpful but pictures, storytelling and clear instructions given through an interpreter were (Spinger et al. 2010:8). Similarly the refugees interviewed by Beatson (2013:144) appreciated clear explanations with repetition to understand medical terms and diagnosis. Kell et al. (2005:33) recommends using information sheets in a variety of languages with audio or visual format for illiterate parents. Tobin et al. (2014:163) found that some information was available in written form but it covered relatively few languages and there was no material for illiterate patients.

Ideally, culturally competent nursing would include information accessible through appropriate formats to everyone from different backgrounds (Papadopolus 2008:16). With current squeezing of public finances it is easy to see why health budgets may find it difficult to provide information in a wide variety of languages, especially for rarer languages. Nevertheless the importance of effective communication to empowerment has been emphasized by Papadopolus (2008:16) among others. Tobin et al. (2014) found that communication barriers prevented good patient relationships and made it difficult to gain consent.

Nurses also need to remember that communication is a two way process in which information is received as well as given. For Tobin et al. (2014:42) it is important to really focus on listening to patient's beliefs, fears and goals rather than telling them what they need. This approach would fit neatly into the Papadopoulos, Tilki and Taylor model of culturally competent care (Papadopoulos 2008:10). Paris et al. (2006:42) also emphasized the importance of home visitors listening to mothers.

A significant step in the right direction to improve communication would be increasing the availability and quality of interpretation services. Tobin et al. (2014:162) found examples of midwives being forced to use family members as interpreters compromising privacy and safety. Beatson (2013:144) also reported parent's frustrations when their children were used as interpreters. Using family members as interpreters is not part of culturally competent care (Papadopoulos 2008:16-18.). However, Drennan et al. (2005:159) found that using family members as interpreters was a pragmatic choice if there was no other option available. In these cases without help from family members

there is the equally challenging ethical problem of either leaving the patient's needs unmet or proceeding with treatment the patient does not understand. The quality of translation also appears to be an issue with Tobin et al. (2014:162), for example highlighting fears about the accuracy of translation. Spinger et al. (2010:9) noted that it was difficult to find interpreters with sufficient health literacy and Kurth et al. (2010:6) gives examples of hospital staff such as cleaners being used as interpreters. Unfortunately, it is likely that nurses working with refugees will continue to make compromises between less than ideal alternatives. Nevertheless it is hoped that as health care systems adjust to unprecedented numbers of refugees high quality interpretation will become common. Tobin et al. (2014:162) advocate 24-hour access to medically trained interpreters as a mandatory standard and Kurth (2010:10) concludes with a similar plea for well-trained interpreters. Drennan et al. (2005:159) argued for wider use of telephone interpretation and also pointed out that the ethnicity of interpreters is a sensitive issue for refugees from areas of ethnic conflicts. Despite the challenges there were also a number of positive experiences such as Kell et al. (2005:31) highlighting the benefit of using interpreters who are respected members of the refugee community. Kurth et al. (2010:8) highlights how successful collaboration between mental health practitioners and interpreters in addition to extended consultations led to adequate health care for refugees. Overall the results in agreement with previous studies that highlight the importance of accurate translation to overcome language barriers (Taylor 2008:61).

6.2.3 Recommended Training for Nurses

Tobin et al. (2014:164) found that a number of midwives in the study had never had any kind of training in culturally competent care, and Kurth et al. (2010:10) noted that in addition to intercultural training health care workers needed advice on how to identify and treat psychological trauma. Health visitors participating in the study by Drennan et al. (2005:161) wanted more information on national laws regarding asylum, the culture and customs of particular groups and strategies to work with traumatized clients. Background research also indicates that health professionals may feel ill-equipped to deal with the complex medical and social needs of asylum seekers and refugees (Hogg 2010:165).

In the visiting Moms Program described by Paris et al. (2006:37) staff were trained on issues such as culture, parenting styles, identifying trauma, screening for abuse and other topics. Health visitors were also supervised which included opportunities to get advice on challenging situations.

6.2.4 Techniques to Improve Cultural Competence in Nurses

The Papadopoulos, Tilki and Taylor model of culturally competent care defines cultural competence as the ability to provide people from different backgrounds with effective care. Health care workers should listen to how the patient perceives their problem and incorporate their perspective into care (Papadopoulos 2008:18.) There was evidence in the literature review that similar approaches are applied in practice. Drennan et al.(2005:159), explains how experienced health visitors ask the mothers to tell them about their feeding practices, for example, so that the patients view can be taken into account.

The parents interviewed in Beatson's (2013:144) study wanted health professionals to help them access traditional healing practices. Tobin et al. (2014:165) reported that midwives found it strange at first when mothers from other cultures wanted to be mobile during labour and they expected the midwife be present. After a period of adjustment midwives adopted a more flexible approach (Tobin et al. 2014:165). Provided traditional practices do not significantly contradict evidence based practice then there is no reason for nurses to prevent the inclusion of alternative perspectives in care plans.

Previous research has indicated the importance of gaining some specific cultural knowledge about a group (history, geography, sociocultural background) but nevertheless to avoid stereotyping (Taylor 2008:60; Papadopoulos 2008:11-13). Drennan et al. (2005:159) also emphasise the importance of listening with a willingness to learn about other values and cultures. According to Drennan et al. (2005:159) culturally competent care is a concept with many elements including self-awareness, humility and reflection rather than just facts about a particular culture, otherwise there is a risk of stereotyping. This is very similar to the concepts of cultural sensitivity and cultural awareness put forward in the Papadopoulos, Tilki and Taylor model (Papadopoulos 2008:10). Tobin et al (2014:164) also warn about positive stereotypes, such as a particular group being good at breast feeding, undermining those who needed extra help and support.

Using health care professionals with a refugee background is one way to bridge the lack of understanding between nurses and refugee families. Paris et al. (2006:42) report how the Visiting Moms Program uses 'bicultural and multilingual staff with very similar backgrounds to the families being helped. Health visitors are trained to assist with the healing of mental trauma similar in many cases to that they have experienced themselves (Paris et al. 2006:40). In the study by Drennan et al. (2005:158) nine of the 13 health visitors interviewed were immigrants to the UK. In addition, both the Kell et al. (2005:31) case study and Springer et al. (2010:4) highlight the benefits of using interpreters from the

local refugee community. First or second generation immigrants with a refugee background are well represented in the nursing profession in Finland and could be a useful resource to help newly arrived refugees. Another obvious advantage would be improved communication if the nurse and patient share a common language. However nurses need emotional support ensure that the experience of reliving trauma does not affect their own well-being (Paris et al. 2006:40).

6.2.5 Working in Supportive and Multi-Professional Teams

Nursing of refugee families appears to be more effective when professionals work well together. Paris et al. (2006:43) describe health visitors collaborating with pediatricians and psychotherapists among others. The health visitor can help to coordinate services and act as an interpreter in some cases (Paris et al. 2006:43; Kell et al. 2005:32). Furthermore, Burchill (2011:26) proposed new ways of joint working to deal with the complexity, for example, of working within child protection laws.

Tobin et al. (2014: 164) found that working with asylum seekers required extra work, for example, to locate interpreters. In another study the emotional challenges, communication difficulties and needs to comply with national legislation caused the projection of negative feelings towards asylum seekers (Kurth et al. 2010:6).The study also describes the anguish for interpreters of repeatedly listening to traumatic war experiences (Kurth et al. 2010:7). In conclusion the authors call for better support for health professionals (Kurth et al. 2010:7). Similalry, Tobin et al. (2014:165) found that a lack of training, experience and institutional support led to feelings of powerlessness in midwives. The emotional burden of treating patients suffering from significant trauma led to feelings of sadness and worry for the patient long after the shift had ended (Tobin et al. 2014:165).

Health visitors in the Visiting Moms Program described by Paris et al. (2006:44) met once a month with a supervisor share resources and support each other. It is clear that participants in other studies in this literature review would have benefited from this kind of support.

Drennan et al. (2005:162) ends with a plea that collective knowledge and expertise are shared rather than practice through trial and error. Reading through different experiences of health professionals working with refugee families it seems that many are forced to improvise as best they can. As models for best practice are established it is important that nurses are given opportunities to share their expertise at an institutional, national and international level.

7 Conclusion

The findings of this thesis stress the importance of continuity of care in refugee and asylum seeker families to address long-term conditions, including mental illness, rather than short-term care to address acute needs. This group need more support due to unfamiliarity with preventative health care and difficulties to access health care. This thesis has also highlighted various health needs and risk factors, in particular the need for an increased focus on sexual and mental health in this group.

Nursing care could be improved through improved communication, especially by increasing the availability and quality of interpretation. To provide effective care nurses need emotional and practical support from colleagues, opportunities to share knowledge and training on how to meet the unique challenges this group.

Methodological limitations of this thesis have been highlighted previously. A further weakness is that many of the articles in the literature review focused on midwifery rather than nursing. The fact that this field has been forced to address the challenges of caring for refugees and asylum seekers ahead of nursing only further confirms the need for a greater focus on sexual and reproductive health in this group. Whilst the results may not be directly applicable the nursing profession can learn a lot from the early progress made by midwives and health visitors in this area.

A central aim of this thesis was to find evidence of best practice for working with refugee and asylum seeker families. The majority of the articles selected for this literature review provided further examples of the challenges of working with this group with little concrete evidence of the best practice that has been successfully implemented. The exceptions to this are the case studies of Paris et al. (2006) and Kell et al. (2005). Nevertheless all articles had worthwhile recommendations based on practical experience to move towards more effective care. Future research should focus on putting these recommendations into practice so they can be verified and modified as required. Further research on how to meet the unique needs of this vulnerable group is needed. As Drennan et al. (2005:162) argues 'service providers need to pay attention to the specific health and social needs of asylum seeking women, who will unfortunately continue to arrive in the UK and other parts of the world.'

The results of this thesis can be used to improve nurses' knowledge of the challenges faced by refugee and asylum seeker families, as well as provide guidance on how to provide culturally competent nursing care to this group.

References

Beatson, J. (2013) Supporting Refugee Somali Bantu Mothers with Children with Disabilities. *Pediatric Nursing* 39(3) 142-145.

Bischoff, A. Schneider, M. Denhaerynck, K. and Battegay, E. (2009) Health and ill health of asylum seekers in Switzerland: an epidemiological study. *European Journal of Public Health* 19(1), 59-64.

Bolton NHS Foundation Trust (2015) *Asylum Seeker and Refugee Specialist Nursing Service* http://www.boltonft.nhs.uk/services/asylum-seeker-and-refugee-specialist-nursing-service/ Read 18.11.2015.

Burchill, J. (2011) Safeguarding vulnerable families: work with refugees and asylum seekers. *Community Practitioner: The Journal of the Community Practitioners' & Health Visitors Association*. 84(2): 23-26.

Burchill, J. and Pevalin, D. (2014) Demonstrating cultural competence within health-visiting practice: working with refugee and asylum-seeking families. *Diversity and Equality in Health and Care*, 11, 151-159.

Carrigan, C. (2014) Flying Under The Radar: The health of refugees and asylum seekers in Australia. *Australian Nursing and Midwifery Journal*, 21 (9), 22-27.

Coughlan, M. Cronin, P. and Frances, R. (2013) *Doing a Literature Review in Nursing, Health and Social Care.* London:Sage.

Drennan, V. and Joseph, J. (2005) Health visiting and refugee families: issues in professional practice. *Journal of Advanced Nursing* 49(2), 155-163.

Eurostat Press Office. (2015) *185 000 first time asylum seekers in the EU in the first quarter of 2015. Eurostat News release 18.06.2015.*

Foundation House (2012) *Promoting Refugee Health Guides: a guide for doctors, nurses and other health care providers caring for people from refugee backgrounds* http://www.foundationhouse.org.au/promoting-refugee-health-guides. Read 18.11.2015

Golafshani, N. (2003) Understanding Reliability and Validity in Qualitative Research, *The Qualitative Report* 8(4), 597-607.

Helsinki Diaconess Institute (2010). *Selvitys kidutettujen ja vaikeasti traumatisoituneiden turvapaikanhakijaja pakolaislasten ja -nuorten määrästä sekä heidän psykiatristen palvelujen tarpeestaan.* Helsinki: Libris Oy.

Hoitopaikanvalinta (2015). *Pakolaiset ja turvapaikanhakija*t http://www.hoitopaikanvalinta.fi/hoitoon-ulkomailta-suomeen/oikeutesi-hoitoon-suomessa/pakolaiset-ja-turvapaikanhakijat/ Read 22.10.2015.

Hogg, C. (2010). Caring for the health needs of migrants, refugees and asylum seekers. In K.Holland and C. Hogg (eds.) *Cultural Awareness in Nursing and Health Care*. London:Hodder Arnold, 165-184.

Kell, B. and Hawkins, F. (2005) Collaboration in eczema care: a case study, *Pediatric Nursing* 17(4), 30-33.

Kemp, C. (2008) Promoting Healthy Partnerships With Refugees and Immigrants. In Anderson, E. and McFarlane, J. (eds.) *Community as Partner Theory and Practice in Nursing*. Philadelphia:Wolters Kluwer, 357-368.

Kurth, E., Jaeger, F., Zemp, Tschudin, S., Bischoff, A. (2010) *Reproductive health care for asylum-seeking women - a challenge for health professionals*. *BMC Public Health 10,* 659-670.

Laki kansainvälistä suojelua hakevan vastaanotosta sekä ihmiskaupan uhrin tunnistamisesta ja auttamisesta, 17.6.2011/746 § 26
Terveydenhuoltolaki, 30.12.2010/1326 §50
Erikoissairaanhoitolaki, 1.12.1989/1062 §3

Logan University: Learning Resources Center (2015) *Literature Review: Ethical Issues* http://libguides.logan.edu/c.php?g=181964&p=1198011 Read 22.11.2015.

Migri (2015). *Kiintiöpakolaiset*. http://www.migri.fi/turvapaikka_suomesta/kiintiopakolaiset Read 8.9.2015.

Migri (2015). *Turvapaikka ja pakolaistilastot*. http://www.migri.fi/tietoa_virastosta/tilastot/turvapaikka-_ja_pakolaistilastot Read 8.9.2015.

THL - National Institure for Health and Welfare (2015). *Turvapaikanhakijat https://www.thl.fi/fi/web/maahanmuuttajat-ja-monikulttuurisuus/vaestoryhmat/turvapaikanhakijat* Read 26.11.2015.

Turvapaikanhakijoiden terveys ja hyvinvointi https://www.thl.fi/fi/web/maahanmuuttajat-ja-monikulttuurisuus/vaestoryhmat/turvapaikanhakijat/turvapaikanhakijoiden-terveys-ja-hyvinvointi Read 26.11.2015.
Turvapaikanhakijoiden mielenterveyden tukeminen https://www.thl.fi/fi/web/maahanmuuttajat-ja-monikulttuurisuus/vaestoryhmat/turvapaikanhakijat/turvapaikanhakijoiden-traumat-ja-mielenterveyden-tukeminen Read 26.11.2015.

Paris, R. and Bronson, M. (2006) A Home-Based Intervention for Immigrant and Refugee Trauma Survivors: Paraprofessionals working with High-Risk Mothers and Infants. *Zero to Three*, 27(2) 37-45.

Papadopoulos, I. (2008) The Papadopoulos, Tilki and Taylor model for developing cultural competence. In Papadopoulos, I. (ed.) *Transcultural Health and Social Care: Development of Culturally Competent Practitioners.* London: Elsevier, 7-24.

Saari, S. (2012) *Kuin salama kirkkaalta taivaalta: kriisit ja niistä selviytyminen.* Keuruu: Otava.

Springer, P., Black, M., Martz, K. Deckys, C. and Soelberg, T. (2010) Somali Bantu Refugees in Southwest Idaho: Assessment Using Participatory Research. *Advances in Nursing Scienc*e 33(2), 170-181.

Taylor, G. (2008) Migrants and Refugees in In Papadopoulos, I. (ed.) *Transcultural Health and Social Care: Development of Culturally Competent Practitioners.* London: Elsevier, 45-64.

Tobin, C. and Murphey-Lawless J. (2014) Irish midwives' experiences of providing maternity care to non-Irish women seeking asylum. *International Journal of Women's Health* 6, 159-169.

UNCHR (1951) *Convention and protocol relating to the status of refugees*. Page 14.

UNHCR (2014). *World at War*, *UNHCR Global Trends Forced Displacement in 2014,* 1-55.

The Leeds Teaching Hospitals (2015) *Caring for Asylum Seekers and Refugees*. http://www.leedsth.nhs.uk/a-z-of-services/leeds-perinatal-centre/professionals/caring-for-asylum-seekers-and-refugees/ Read 18.11.2015.

Thomas (2003) A general inductive approach for qualitative data analysis. http://fycs.ifas.ufl.edu/swisher/6802_15/Inductive2003.pdf [online] Read 8.2.2016.

Whittmore, R. and Knafl, K. (2005) 'The integrative review: updated methodology', *Journal of Nursing Advanced Nursing*, 52 (5): 545