Caring Relationship Between Humanitarian Aid Nurses and Their Patients in the Field

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Degree Thesis
Nursing
2019

DEGREE THESIS	
Arcada	
Degree Programme:	Nursing
Identification number:	5878
Author:	Kukka Nuora
Title:	Caring Relationship Between Humanitarian Aid Nurses and Their Patients in the Field
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Commissioned by:	Master's degree program in Global Health Care at Arcada University of Applied Sciences

Abstract:
The current state of research on nurses and humanitarian aid work focuses mainly on the experiences, education, and professional acquirements of the nurses. There is little research on the caring relationship in the humanitarian aid context. The purpose of this study is to explore the caring relationship between humanitarian aid nurses and their patients in the field, as well as, to find out what factors affect the caring relationship. The theoretical framework for the caring relationship is based on Katie Eriksson's theory in which the caring relationship is open and the abilities of both parties affect it. Caring relationship is basis for the caring process, which aim is optimal health. In humanitarian aid context the caring relationship is multicultural and therefore the theoretical framework includes also concepts of cultural and transnational competence. The data of this research is based on six semi-structured interviews with Finnish humanitarian aid nurses. The data from the interviews is analyzed with qualitative content analysis in three phases. The phases are: preparation, organizing, and reporting. Factors affecting the caring relationship between the humanitarian nurses and their patients are people. Interpreters, who aid in communication, local colleagues, who do most of the nursing, care takers, who perform basic care, and in many cases decide on the care of the patient, other patients, both in giving hope and taking it away. What can be seen to have the greatest effect is the patient and nurse themselves, their understanding of the situation and the other, their skills and attitude. The skills of the persons involved are in the theoretical focus, not specific knowledge on the situation. Analytical, emotional, creative, communicative and functional competencies are required from the involved parties.

Keywords:	Caring relationship, humanitarian aid, nurse, cultural competence, transnational competence, content analysis, semi-structured interview
Number of pages:	70
Language:	English
Date of acceptance:	11.2.2019

OPINNÄYTE	
Arcada	
Koulutusohjelma:	Nursing
Tunnistenumero:	5878
Tekijä:	Kukka Nuora
Työn nimi:	Hoitosuhde humanitaarista avustustyötä tekevien sairaanhoitajien ja heidän potilaidensa välillä kenttätyössä
Työn ohjaaja (Arcada):	Gun-Britt Lejonqvist
Toimeksiantaja:	Master's degree program in Global Health Care at Arcada University of Applied Sciences

Tiivistelmä:
Tämänhetkinen tutkimus sairaanhoitajista ja humanitaarisesta avusta keskittyy pääasiassa sairaanhoitajien kokemuksiin, koulutukseen ja ammatillisiin vaatimuksiin. Tutkimusta hoitosuhteesta humanitaarisen avun kontekstissa on tehty vähän. Tämän lopputyö pyrkii tarkastelemaan hoitosuhdetta humanitaarista avustustyötä tekevien sairaanhoitajien ja heidän potilaidensa välillä kenttätyössä, sekä selvittämään mitkä tekijät vaikuttavat hoitosuhteeseen. Teoreettinen viitekehys hoitosuhteelle perustuu Katie Erikssonin teoriaan, jossa hoitosuhde on avoin ja siihen vaikuttavat molempien osapuolten kyvyt. Hoitosuhde on perusta hoitoprosessille, jonka päämääränä on optimaalinen terveys. Humanitaarisessa avustustyössä hoitosuhde on monikulttuurinen ja sen vuoksi teoreettinen viitekehys sisältää myös kulttuurisen ja transnationaalisen kompetenssin. Tutkimuksen aineisto perustuu kuuteen puolistrukturoituun haastatteluun suomalaisten avustustyötä tehneiden sairaanhoitajien kanssa. Haastatteluista saatu aineisto analysoidaan kvalitatiivisella sisällönanalyysillä kolmivaiheistesti. Vaiheet ovat: valmistelu, järjestely ja raportointi. Tekijät, jotka vaikuttavat humanitaarista avustustyötä tekevien sairaanhoitajien ja heidän potilaidensa väliseen hoitosuhteeseen, ovat muut ihmiset. Tulkit, jotka auttavat kommunikaatiossa, paikalliset kollegat, jotka suorittavat suurimman osan hoitotyöstä, omaishoitajat, jotka suorittavat perushoidon ja monissa tapauksissa päättävät potilaan hoidosta, muut potilaat, jotka antavat toivoa, mutta myös vievät sitä pois. Suurin vaikutus voidaan kuitenkin nähdä olevan potilaalla ja sairaanhoitajalla itsellään, heidän ymmärryksensä tilanteesta ja toisesta osapuolesta, heidän taidoillaan ja asenteillaan. Osallisena olevien ihmisten taidot ovat teoreettisessa keskiössä, ei kattava tieto tilanteesta. Osallisilta kysytään analyyttistä, emotionaalista, luovaa, viestinnällistä ja toiminnallista kompetenssia.

Avainsanat:	Hoitosuhde, humanitaarinen avustustyö, sairaanhoitaja, kulttuurinen konpetenssi, transnationaalinen kompetenssi, sisällönanalyysi, puolistrukturoitu haastattelu
Sivumäärä:	70
Kieli:	Englanti
Hyväksymispäivämäärä:	11.2.2019

CONTENTS

FOREWORD

In here I would like to take the opportunity to acknowledge persons who have contributed to this thesis process. This thesis would not be here without the six informants who gave their time and opened up the world of a humanitarian aid nurse to me. Therefore, I want to thank them greatly. I would also like to express my gratitude to my supervisor, Gun-Britt Lejonqvist, who supported me through the process with her encouraging attitude and critical discussions.

1 INTRODUCTION

From the establishment of the nursing profession nurses have went abroad to ease the human suffering. A contemporary form of this is humanitarian aid. This thesis focuses on the humanitarian aid nurses work on humanitarian missions and the caring relationship with patients on those missions.

Six Finnish female nurses are interviewed for this research and their understanding of the factors affecting the caring relationship are analyzed. Together the informants have been on 27 humanitarian missions as nurses. Sending organizations include Red Cross and Red Crescent Movement, which includes the Finnish national Red Cross, the International Federation of Red Cross and Red Crescent Societies, as well as, the International Committee of the Red Cross, Fida International, and Médecins Sans Frontières, also known as Doctors Without Borders.

The current state of research in Finland and Sweden, as well as, the English academic literature on nurses and humanitarian aid work focuses mainly on the experiences, education, and professional acquirements of the nurses (see for example: Aalto and Järvensivu 2017; Bjerneld, Lindmark, Diskett, and Garrett 2004; Björklund and Bornander 2012; Nordström and Vesterlund 2012; Riikonen 2005; Salomonsson and Burénius 2012; Svensson and Thore 2016). The studies describe how to handle the demanding working environments and what kind of skills the nurses should acquire.

Few studies focusing on the caring relationship between humanitarian aid nurses and their patients can be found. A Bachelor's thesis by Dorell and Jonsson (2010) aims to describe nurses experiences on encounters with patients in crisis areas. This research aims to go further and analyze the caring relationship between the humanitarian nurses and their patients and to analyze the influencing factors.

The purpose of this study is to shift focus form the education and knowledge that is required of the humanitarian aid nurses into the cooperation with the patients in the caring relationship. Also, to provide understanding on the caring relationship between nurses

and their patients in the context of humanitarian aid. Hence, shed light on the factors affecting the caring relationship.

The idea for this thesis is connected to the researcher's motivation to pursue nursing studies. Already during my Peace and Conflict Studies in Malmö University at bachelor's level I developed interest to do something practical on the grassroots level, to combine both theory and practice, and to work with people. After completing my master's degree on Peace and Conflict Transformation at UiT The Arctic University of Norway I began at the Nursing program at Arcada University of Applied Sciences.

The researcher has been a volunteer at the Finnish Red Cross since 2013 and hold positions of trust on branch, district and national level. This thesis is not commissioned by the Finnish Red Cross and the Red Cross has only been connected to the research project by sending an invitation to its delegates to participate in the study. This thesis is commissioned by the master's degree program in Global Health Care at Arcada University of Applied Sciences.

1.1 Humanitarian Aid

Here will follow definition on humanitarian aid to give the reader understanding of the frame that the humanitarian aid nurses are working in. The definition of humanitarian aid lacks consensus and "reflect[s] the diversity of organizations and institutions (EUPRHA 2013: 7).

Humanitarian aid as defined by European Universities on Professionalization on Humanitarian Action (EUPRHA) in their report *The State of Art of Humanitarian Action: A Quick Guide on the current situation of Humanitarian Relief, its Origins, Stakeholders and Future* (2013: 7) is "generally considered a fundamental expression of the universal value of solidarity between people and a moral imperative."

Due to the limits of this thesis the moral implications of humanitarian aid are not discussed in this section only a short definition of humanitarian aid is provided. This is for the reader to understand what is generally considered to be included under this concept

and therefore to be able to situate the work of the humanitarian aid nurses into a bigger frame.

The European Consensus on Humanitarian Aid, defined together by the European Union (EU) Member States, the European Parliament, the European Commission and Council and supported by the main European NGOs, "defines the aim of humanitarian aid: to provide a needs-based emergency response aimed at preserving life, preventing and alleviating human suffering and maintaining human dignity wherever the need arises if governments and local actors are overwhelmed, unable or unwilling to act." (EUPRHA 2013: 7).

Crises where humanitarian aid is needed include both man-made and natural disasters, consisting of factors such as climate change, competition for access to energy and natural resources, extreme poverty, poor governance (The European Council 2008). The people affected most by these crises are usually the poorest and most vulnerable civilians living in developing countries (The European Council 2008).

In the beginning of the 2010's humanitarian action industry constituted of around 4400 Non-governmental organizations and was worth of US $13 billion (EUPRHA 2013: 7). An estimate of 274 000 humanitarian aid workers working worldwide, excluding governments, corporations, military and others that could be added to the number (EUPRHA 2013: 7).

1.2 Overview of the Thesis

After this introduction a short review of earlier research is presented, then theoretical framework. The cultural competence and transnational competence theories are discussed, including a definition of caring relationship in the context of this research. Then will follow the objectives of this research, where also the research question is laid out. Methodology chapter describes the semi-structured interview method, presents the informants, and the interview procedures, as well as the ethical considerations. In the methodology chapter the qualitative content analysis, which is used to analyze the data is presented. Then will follow the results of the data, divided into six main categories, which

are further divided into two to three sub-categories. Discussion will follow the results and the thesis is ended by a conclusion.

2 RESEARCH REVIEW

Research in Finland and Sweden, as well as, the English academic literature on nurses and humanitarian aid work focuses mainly on the experiences, education, and professional acquirements of the nurses (see for example: Aalto and Järvensivu 2017; Bjerneld, Lindmark, Diskett, and Garrett 2004; Björklund and Bornander 2012; Nordström and Vesterlund 2012; Riikonen 2005; Salomonsson and Burénius 2012; Svensson and Thore 2016), or ethics on the field (Hunt 2008; Schwartz et al. 2010). The studies describe how to handle the demanding working environments and what kind of skills the nurses should acquire.

Few studies focusing on the caring relationship between humanitarian aid nurses and their patients can be found. Dorell and Jonsson (2010) in their bachelor's thesis on nursing aim to describe nurses' experiences on encounters with patients in crisis areas. Through six on-phone qualitative semi-structured interviews they were able to identify analytical categories of *a good encounter, factors that affect the encounter* and *meaningful factors to overcome difficulties*. Their analysis lacks a deeper description and analysis of the encounters, focusing in the research on the qualities of the nurses and the situational factors. Patients and their role is minor, including the most important point from an informant, that patients also have to adjust to get the care, is left without further analysis. In their research they identified as the most important factor that affects the encounter being the nurse's behavior towards the patient. (Dorell and Jonsson 2010)

3 THEORETICAL FRAMEWORK

In this chapter the theoretical background of the research is presented and discussed. First, the concept of caring relationship is defined in relation to this research. As the humanitarian aid nurses work in multicultural environments additional requirements on all the parties involved in the caring relationship are present. Two models, dealing with multicultural encounters within healthcare are introduced and discussed in here. The first one is represented by Madeleine Leininger, who underlines the knowledge about cultural qualities and understanding of the individual's, family's, and group's values (Vanne and Putkinen 2010: 3). Cultural competence theory focuses on the healthcare professional's knowledge about cultures.

Transnational competence includes the patient's participation, the person's own narrative, interaction through dialog, exchange of knowledge and mutual understanding (Sainola-Rodriguez 2010: 20-21). This model has its focus on the person, patient and healthcare professional, as well as, their personal skills and sensitivity towards other cultures. The model does not expect the healthcare professional to have deep knowledge on many cultures, but a genuine interest for the patient's situation and the cultural aspects defined by the patient themselves that affect the situation (Sainola-Rodriguez 2010: 21).

3.1 Caring Relationship

Verena Tschudin (1986: 1) writes about the introduction of the nursing process that has changed nursing profoundly. It has shaken the relationship between nurses and patients (Tschudin 1986: 1). This shift in nursing, which started in the 1950's, especially in the USA (Eriksson 1990: 13), has taken nurses out of the comfort zone of seeing only the illness to be cured and tasks to be performed, and forced them to see patients as individual persons and to form caring relationships with them (Tschudin 1986: 1).

The nursing process, also called caring process, has many different definitions. For the purpose of this thesis Katie Eriksson's (1990) definition of caring process is used. The utmost aim of the process is optimal health (Eriksson 1990: 25). It includes phases: 1)

patient analysis, the mapping of the patient's situation; 2) prioritizing the care area; 3) choice of care actions; 4) care and care actions (Eriksson 1990: 25-26).

According to Katie Eriksson (2002: 63) "[a]ll caring is formed in the relationship between patient and caregiver." This relationship is the basis of care and the caring process (Eriksson 1990: 55). Still, the caring process is an open system, which means that it changes energy, material and information with its surroundings (Eriksson 1990: 20). The patient's family or primary group and society take part in the decisions of the care (Eriksson 1990: 21).

The relationship between nurses and patients can be seen as very unequal one, even paternalizing (Tschudin 1986: 12). Due to the introduction of the nursing process this has been turned upside-down, and "nurses are becoming cooperators, companions, co-responsible for care, not deliverers of it" (Tschudin 1986: 12).

"The core of the caring relationship, between nurse and patient as described by Eriksson […], is an open invitation that contains affirmation that the other is always welcome." (Grönroos, Lindholm and Lindström 2010: 199). In the relationship with the carer, the patient shall get space to express their actual desires, needs, and problems (Eriksson 1990: 55).

The relationship is built on mutuality, which means that it progresses from the abilities of both the patient and the carer (Eriksson 1990: 55). 'Giving' and 'receiving' portray the caring relationship (Eriksson 1990: 55). The intensity and depth of the relationship varies (Eriksson 1990: 55).

The caring relationship is professional, which means that it is built upon knowledge and it fulfills the ethical requirements (Eriksson 1990: 55). In its character the caring relationship aims towards health (Eriksson 1990: 26) and to support the patient's caring process (Eriksson 1990: 55).

3.2 Cultural Competence

Cultural competence, which is based on theories of transcultural nursing developed by Madeleine Leininger, is a process that describes the cognitive, affective and skill qualities that a healthcare professional needs to be able to meet the care needs of a patient from a different cultural background (Sainola-Rodriguez 2010: 19).

Transcultural nursing as a subfield emerged in the mid 1960's from Leininger's initiation (Leininger 1978: 1). Different theorists have developed conceptual models on cultural competence. Irena Papadopoulos and Shelley Lees (2002: 258) sum the model into four concepts: cultural awareness, cultural knowledge, cultural sensitivity and cultural competence. Josepha Campinha-Bacote (2002: 182) has five concepts represented in her theory: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire.

Kirsti Sainola-Rodriguez (2010: 20) presents six concepts: cultural awareness: understanding of others and one's own cultural background; cultural knowledge: seeing the differences and similarities of different cultures; cultural sensitivity: appreciating culture and taking it into account in care planning; cultural competency: recognizing cultural needs, important information and communication and interaction skills; cultural encounter: meeting people from different cultures as individuals, recognition of differences between groups; and cultural will: genuine interest and motivation to help.

According to cultural competence model, healthcare professional has an active role to collect knowledge on both their own and other cultures to better understand the patient. After the knowledge comes the skills of the healthcare professional, such as, communication, will, and motivation to understand the patient and their cultural background.

3.3 Transnational Competence

The transnational competence model, developed by two American political scientists Peter Koehn and James Rosenau, is a general perspective towards different international and transnational encounters (Sainola-Rodriguez 2010: 20).

The dimensions of transnational competence are: analytical: ability to search for, locate, select, assemble, organize, interpret, critically assess, and apply relevant generic and context-specific knowledge, data, and rules; emotional: motivation and ability to open oneself up continuously to divergent cultural influences and experiences; creative/imaginative: ability to foresee and exploit the synergistic potential of diverse group perspectives in collective problem solving; communicative: proficiency in and use of counterparts' spoken/written language, skill in interpretation and in using an interpreter, and proficiency in and relaxed use of interculturally appropriate nonverbal cues and codes; and functional competence: ability to relate to counterpart(s) and to develop and maintain positive interpersonal relationships (Koehn and Rosenau 2010: 8-16).

In the transnational model the focus is neither on a specific culture nor on a patient from a specific culture, Sainola-Rodrigues (2010: 20) declares that the model is useful in every encounter within a healthcare setting. The dimensions shift the focus on solid knowledge to application and interpretation of gained knowledge through global and local experiences.

> Emotionally skillful participants also appreciate that every clinical encounter is a multidimensional interaction among the cultures of the patient, the physician, the support professional(s), and the healthcare contexts/systems that surround them. (Koehn 2006: 6)

The transnational competence model includes not only the abilities of the participants of the transboundary encounter and micro environment, but the macro forces and environment should also be considered by competent participants.

The responsibility for a successful encounter is not only on the healthcare professional, but also the patient's transnational competence plays a role (Sainola-Rodriguez 2010: 21). Sainola-Rodriguez (2010: 20-21) lists patient's involvement, person's own narrative, interaction through dialog, exchange of knowledge, and mutual understanding, which further the consensus on the view on health, which then is hoped to lead to good care results.

The model stirs the focus from knowledge towards skills, from the healthcare professional towards cooperation and dialog. The healthcare professional is not the only active participant, but the patient shall also take an active role and have skills to meet the professional from another background.

3.4 Summary

Research in Finland and Sweden on nurses and humanitarian work is mostly focused on the experiences and professional abilities of the nurses. Patient's role and input in the careing relationship does not seem to exist as a viewpoint. Katie Eriksson's definition on caring relationship underlines its cooperative nature and the space for the patient to express their needs.

Cultural and transnational competence are concepts to use, also internationally, to research transnational encounters between healthcare professionals and patients. The healthcare professional has an active role, according to the cultural competence model, to acquire knowledge both on their own culture and the culture of the patient to better fulfill the care needs of the patient. The transnational competence model does not focus on knowledge on specific cultures, but on the abilities of the healthcare professional and the patient to reach good care results. The responsibility of the success of the encounter is not only on the professional but also on the patient's transnational competence plays an important role. Also, not only the local context is to be considered but also more global forces should be taken into account when considering the transnational encounters.

4 OBJECTIVES OF THE RESEARCH

The main objectives of this research are to explore the caring relationship between humanitarian aid nurses and their patients and to identify factors that influence the caring relationship between them.

Through the understanding of the caring relationship, factors that influence it are explored. Factors promoting and hindering a good caring relationship between nurses and patients are sought after to be analyzed.

The viewpoint of this research is the humanitarian aid nurses'. Nurses are interviewed on their perception of the caring relationship between them and their patients on the humanitarian missions. The viewpoint of the patients' is left out from the scope of this study due to resource and time limitations.

4.1 Research Question

- What factors affect the caring relationship between humanitarian aid nurses and their patients?

5 METHODOLOGY

In this chapter the methodological framework of this research will be presented. The research of this thesis is qualitative and data collection method is interviewing. The purpose of qualitative interview lies in "asking questions and prompting conversation in order to gain information and understanding of social phenomena and attitudes." (Walliman 2009: 131) Together six semi-structured interviews were conducted, following an interview guide consisting of eight open-ended questions (see Appendix 4).

Analysis of the data gathered with the interviews is based on qualitative content analysis, used in the inductive way. This method was chosen due to its flexibility and wide use in nursing science. This method of analysis is presented in this chapter.

5.1 Semi-Structured Interview

One of the most used data collection method is interview, which can be divided into structured, semi-structured and unstructured interviews (Whiting 2008: 35). Semi-structured interview, often used by healthcare professionals (Whiting 2008: 36), relies on pre-set open-ended questions (Hesse-Biber and Leavy 2011: 102). These questions are seen as a guide for the conversation-like interview and allow room for the interviewee to express themselves (Hesse-Biber and Leavy 2011: 102). Unstructured interview is based on a topic and the conversations can flow freely around it (Hesse-Biber and Leavy 2011: 102).

The qualitative in-depth semi-structured interview of this research is based on open-ended questions on pre-prepared interview guide:

> The in-depth interview is important to qualitative research because it uses individuals as the point of departure for the research process and assumes that individuals have unique and important knowledge about the social world that is ascertainable and that can be shared through verbal communication. (Hesse-Biber and Leavy 2011: 94)

The data gathered through this kind of method can be considered exploratory and descriptive; "thick descriptions" of social life (Hesse-Biber and Leavy 2011: 94-95).

Cohen and Crabtree (2006) describe the characteristic of semi-structured interview: "the interviewer develops and uses an 'interview guide'. This is a list of questions and topics that need to be covered during the conversation, usually in particular order." Inclusion of open-ended questions allow the interviewer to follow the flow of the interview, and "identify new ways of seeing and understanding the topic at hand" (Cohen and Crabtree 2006). The in-depth interview is described as a partnership between the researcher and the informant (Hesse-Biber and Leavy 2011: 94). Active listening and asking are the key components of this kind of interview (Hesse-Biber and Leavy 2011: 94).

"The semi-structured interview guide provides a clear set of instructions for interviewers and can provide reliable, comparable qualitative data." (Cohen and Crabtree 2006). Still, allowing questions to emerge from the dialogue between the interviewer and informant (Whiting 2008: 36). Semi-structured interview then both includes a clear interview guide with topics and questions and allows the interviewer to follow up the interviewees understanding of the topic at hand. "Semi-structured interviews also allow informants the freedom to express their views in their own terms." (Cohen and Crabtree 2006).

The interviewer is usually expected to control the interview by using the interview guide, but not to contribute to the interview in any other way (Whiting 2008: 36). This view has also been criticized as not "respecting the role of participants" as they are only expected to produce data (Whiting 2008: 36).

Hesse-Biber and Leavy describe the semi-structured interview as allowing "the conversation to flow more naturally, making room for the conversation to go in unexpected directions" and to "explore[] new topics that are relevant to the interviewee" as well (2011: 102). They characterize it as a *meaning making partnership* (Hesse-Biber and Leavy 2011: 105). The approach used in this research is seen more as a conversation between the researcher and the informant, a way of exploring the topic together, not merely as a means of producing data.

The focus of this research is on the caring relationship between nurses and patients on humanitarian missions. Although, the relationships are formed and played out on the mis-

sions, the data is gathered after the missions. When fieldwork is out of the limits of a particular research and the topic does not limit itself "to a particular setting" but data can be gathered from informants outside the setting, in-depth interview can be considered as a suitable option (Hesse-Biber and Leavy 2011: 94-95).

5.1.1 Sampling of Informants

Sharlene Nagy Hesse-Biber and Patricia Leavy (2011: 46) point out the reality of fieldwork, where researchers are often limited to those informants who are available and willing to participate in the research. This type of sampling is called convenience sampling (Hesse-Biber and Leavy 2011: 46), which is also used in this study.

The informants were contacted through their sending organization the Finnish Red Cross (see Appendix 1), also a request was sent to Doctors Without Borders, but no answer was received. Other means of finding informants were through the researcher's personal and professional contacts, who had acquaintances they were willing to contact on behalf of the researcher.

In the time and space limitations of this study the number of informants is limited. Together six informants were interviewed for the research during May-July 2018.

5.1.2 Informants

There are together six informants interviewed for this research, all of them having a Finnish nurse's education and four of them have additionally a master's Degree either related to Healthcare, Management or Economics. The informants are all women ranging from working age to retired. They have been together out on 27 missions as nurses, two of them have done also missions on management level, but those are not included into the count. Sending organizations are Red Cross and Red Crescent Movement, including the Finnish national Red Cross, the International Federation of Red Cross and Red Crescent Societies, as well as, the International Committee of the Red Cross, Fida International, and Médecins Sans Frontières, also known in English as Doctors Without Borders. The duration

of the missions varies from as short as two weeks to four-year-long development aid projects. The missions have been in Asia, including countries such as Bangladesh, India, Tajikistan, Thailand, Sri Lanka, in Africa, including Central African Republic, Ethiopia, Kenya, Niger, South Sudan, Uganda, Tanzania, in Middle East, in Afghanistan and Yemen, in Central America in Haiti.

5.1.3 Interview Procedures

There was one interview with each informant. The duration of the interviews varied from 45 minutes being the shortest and 1 hour and 15 minutes the longest of them. An hour was the estimated time for the interviews in beforehand, which was quite accurate estimation as the average time was 54 minutes. All the interviews were tape recorded.

Two of the interviews were done face-to-face with the researcher and the informant present, but as this was not possible due to geographical distance, the four other interviews were done by using Skype application.

In the face-to-face interviews, which were done in public places, background noise in the recording disturbed the transcribing process somewhat. By using Skype application in the other interviews caused some connection problems, especially in one of the interviews, in others some minor disturbances can be found on the recordings.

Two of the interviews were done in English as the informants had Swedish as their native language. Other four interviews were conducted in Finnish. The citations from the interviews that are in Finnish were translated by the researcher. The translations are done to the best ability of the researcher but should be considered as free translations.

5.2 Ethical Considerations

Ethical consideration has to be tackled in relation to this research both to ensure the integrity of the research and the people interviewed, i.e. informants.

A research proposal was presented to the Arcada's board of ethics for approval. The research follows Arcada's ethical rules, found in the document Good Scientific Practice in Studies at Arcada (Arcada ND). These rules are in line with Guidelines for Good Scientific Practice of the National Advisory Board on research Ethics in Finland issued 2002. The World Medical Association's (2018) WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects is also followed.

Integrity of the informants was ensured by informed consent and anonymity. The informants were given a consent form (Appendix 2 and 3), which presented the purpose of the research, the way the collected data would be handled, and the rights of the informants. The informants had the full right to decline to participate at any stage of the research without any reason or consequences. The anonymity of the informants is executed by referring to their interviews with letters, as well as, taking away specific places or other details.

The researcher is a volunteer and holds positions of trust in the Finnish Red Cross. This connection is made clear and is to be considered in relation to the integrity of the research. The Finnish Red Cross has only been connected to the research project by sending an invitation to its delegates to participate in the study (see Appendix 1). The researcher has not discussed the unfinished project with anyone within the organization.

5.3 Qualitative Content Analysis

Inductive content analysis is used in the analysis of the data, e.g. interviews. Inductive approach derives its concepts from the data in contrast to deductive approach in which the analysis bases to previous research and its concepts. Although, there is previous research (Dorell and Jonsson 2010), which could suggest that a deductive content analysis is used. The objectives of this research support the inductive approach. The data will also be better understood trough an inductive approach, where the focus is on the primary data and its meanings.

The method of content analysis is used to systematically describe a phenomena with the aim of "a condensed and broad description of the phenomen[a]" (Elo and Kyngäs 2008:

108). Final outcome is "a model, conceptual system, conceptual map or categories" (Elo and Kyngäs 2008: 108). Content analysis, in other words, is used to make sense of the data in a systematic and cohesive way, which makes the analysis easier to others to understand and to test. This process also aims to show the strengths and limitations of the analysis (Elo and Kyngäs 2008: 112), which then gives validity to the research.

Content analysis was chosen for this study for its flexibility in structure and the focus on the data itself. The process of analysis is divided into three phases: preparation, organizing, and reporting (Elo and Kyngäs 2008: 109).

In the preparation phase, the unit of analysis is chosen (Elo and Kyngäs 2008: 109), which in this case is a factor/phenomenon affecting the caring relationship in the studied context. This phase is also meaning making phase, where the researcher makes sense of the data (Elo and Kyngäs 2008: 109). The unit of analysis can include manifest and/or latent content (Elo and Kyngäs 2008: 109). Latent content includes such as, "silence, sighs, laughter, posture etc." (Elo and Kyngäs 2008: 109). In this research the manifest content is the focus of the analysis, as what is said by the informants is analyzed and not how they are saying it.

Next phase, the organizing phase, focuses on the categories and the organization of them (Elo and Kyngäs 2008: 109). This can be also considered as coding of the data. This means that when reading the data, the researcher writes the headings, e.g. codes, in the text (Elo and Kyngäs 2008: 109). This process is repeated as many times as needed to find all the headings necessary (Elo and Kyngäs 2008: 109). This phase was done by highlighting in the transcripts the mentioned categories; then collecting the highlighted parts of the transcripts together according to the categories. A chart of the different categories was also done, where was stated in which interview a category was mentioned and on which transcript page it can be found, as well as, the main point made by the informant on that category.

The third phase, reporting, presents the results of the analyzing process, which is then shown in the "model, conceptual system, conceptual map or categories" created (Elo

and Kyngäs 2008: 110). This is shown in the results chapter. Through these categories a general description of the phenomena is created (Elo and Kyngäs 2008: 111).

6 RESULTS

In this chapter results of the data from the interviews are presented. Six main themes influencing the caring relationship between the delegate nurses and their patients on the humanitarian missions came to prominence from the interviews. Those six themes are: communication, patient's choice, care taker, colleagues, delegate nurse's role, and mental state and violence. These themes are divided into two to three sub-themes.

6.1 Communication

Communication is a theme that arises in every interview in some form as a factor affecting the caring relationship between the nurses and patients. In all of them the lack of common language and using an interpreter is mentioned early on. Under this theme of communication sub-themes of interpreters, non-verbal communication, and other forms of communication, including drawing, as well as, listening are presented.

6.1.1 Interpreters

Every informant highlights that the humanitarian work in other countries includes working with interpreters. They elaborate on how it affects the caring process and on the difficulty of finding qualified interpreters. The topic of interpreters comes up early in the interviews and is an issue that seems to be one of the things that has a great imprint on the work of the nurses, as well as, the caring relationship.

An informant expresses a big issue when working with an interpreter: "Because you don't know if the interpreter is […] interpreting in a correct way […], if they are interpreting everything. Because sometimes I can feel that they don't tell the patient everything that maybe I'm saying […]" (Interview A).

The problem when using interpreters is not only a communicative one, but also causes risk to the whole caring proses, as the following informant explains:

> And it is so often frustrating, when you try to choose your words so, that you definitely ask the right thing and you have no idea what was actually either asked or answered. And I think that it is the biggest thing where really mistakes, mistakes, mistakes are made. And those are definitely made. (Interview F)

Some things are lost in the translation, but an informant sees that the communication is also much poorer because of the need to use interpreters (Interview F). When an interpreter is present it is not only the verbal communication that suffers, but also the non-verbal is impacted: "I always like to say to people, that when you speak through an interpreter, then look into the eyes of the one you are speaking to, don't look at the interpreter. You are not speaking to the interpreter! But it is really hard for people to understand" (Interview F).

The contact between the nurse and her patient is suffering from the presence of an interpreter, as well as, the depth of the communication that can be achieved. What arises from the issues that the informants have brought up, is a mistrust towards the interpreters by the nurses. Many times, they do not have trust on the interpreters, as they say that they feel that everything is not translated or that it is not translated in the correct way.

Despite all the disadvantages expressed by the nurses, the importance of having interpreters and their usefulness is also present in two of the interviews. "[…] we have interpreters, so that we can achieve a certain level of that communication." (Interview D)

Finding good interpreters seems to be rather difficult according to an informant:

> The standard of interpreters is quite… shocking sometimes. You have to take a person for an interpreter, […] from whose language skills we don't know much about. Well, of course we test [them] and try to test in the best possible way, […] then we take the best possible ones. But we try to educate and teach them to learn the vocabulary; some are interested and some are not in the least interested. (Interview F)

Adding to the lack of motivation by some interpreters for self-improvement, is another concern raised by an informant:

> And interpreters, unfortunately, we have to often intervene, not so much on the healthcare staff, that they don't treat the patients with respect, that also happens; because it is very cultural what is quite normal respectful [behavior], but in our mind might seem really horrible… disrespectfulness. But interpreters are often quite rude. (Interview F)

Unqualified interpreters with no medical background and lack of understanding of the caring process is a great issue according to the informants. Although, the need for interpreters is obvious so that a certain level of understanding between the nurse and the patient is achieved, the use of interpreters is also a cause of many kind of problems concerning the caring relationship. The direct contact with the patient can suffer, when the

healthcare professionals address the interpreter rather than the patient; the message can be lost and cause misunderstanding in the caring relationship, which then can cause mistakes in the caring process.

In some situations, it might be preferred not to use interpreter or another person to translate and just manage with the limited verbal skills and non-verbal communications methods:

> […] if there is like some gynecological matter or if you are talking about some contraceptive issues or even like performing an abortion or miscarriage or things like these, it can be that the man in the family is not like willing to translate the issue as it is to the woman. So, in fact you rather would communicate directly [with the patient], although little inadequately, but so that you could somehow [get the message trough]… Another thing is showing compassion which is maybe easier with those few gestures than if you have […] interpreter who works with their rather different personality; someone who transmits your message like… different. So, even if the person hears the words, but they hear them with different tone than I mean. […]. (Interview C)

It is rather situational whether it is preferred to use someone to translate or not, as seen from the comment above in some situations an interpreter can be invaluable and, in some situations, other methods of getting the message through would be preferable. In the next sub-theme, the non-verbal communication methods are analyzed.

6.1.2 Non-verbal communication

Under non-verbal communication are included, for example, body language, voice, touch, and drawing. As expressed by an informant in the section above, voice and tone can be really important, it can alter the message greatly. Under this sub-heading the importance and the possibilities of non-verbal communication is presented.

An informant demonstrates that body language including expressions and gestures become important, when you do not have a common language (Interview E). The caring situation is for the patient usually unfamiliar, so there is a need to communicate many things and here the non-verbal communication can be used (Interview E). The informant continues that the non-verbal communication becomes easier when you know the patient better and makes it even fun and rewarding:

> Then when you know each other a little and the patient has been there a week or two, then it starts to work and it becomes often like fun and hilarious, the care, when you try like, without words, with sign language to tell what is being done. (Interview E)

As discussed under the interpreter sub-heading, it might be hard to get contact with the patient when using an interpreter. An informant has a solution for that: "[…] with eye contact you get a lot, with smiling eyes. I always say that smile with your eyes, then the patient will notice it." (Interview F) Here an expression is used to get contact with the patient and to communicate with them.

An informant also pointed out that body language can be tricky: "You can show very different things with nonverbal communication… if you are not careful and… observe these things." (Interview B) By observing she means observing the surrounding culture and its customs. Body language is tied to the local culture and therefore she warns that you can go wrong with it if you are not aware of the culture you are in.

The conduct of the nurse then is seen as a crucial for the caring relationship and how it is built from the start. An informant sees the way you meet the patient as an important building stone for trust between the nurse and the patient. "[…] the quality of the meeting […] whether you can meet the expectations what they [the patient] have and whether you can create such an atmosphere, that the person can freely tell what are their needs." (Interview D) The informant both says that it takes time to build trust, but that you also need to create the good circumstances for the trusting relationship quickly as there are a lot of patients that the nurses have to treat (Interview D).

What this conduct is can be then seen on the other parts of this sub-chapter. Body language, listening, touch, and taking time to make sure that you understand each other, whether it be trough interpreter or drawing or sign language.

One things that is both cultural and in the job description of the humanitarian nurses, is avoidance of touch. "[…] in some cultures it is really difficult to touch the patient [for] doctors and even nurses. It is quite interesting thing, that [touching] is missing." (Interview F) As will be later in this chapter discussed, the humanitarian nurses are often not the ones working directly with patients. Therefore touch is a tool that the nurses get to use rarely in a caring relationship.

Touching the patient when examining or when conducting other kind of care is missing from some cultures, which is contrast to the caring culture the above informant comes from. She also wonders how the patients might receive it, if done by a healthcare professional: "[…] I have no idea how a patient would take it if you would touch them. Whether it would feel good or if they also would shun it a little." (Interview F) In direct patient care, the informant sees the problem of custom, it is not only whether you are allowed or not to touch in the local culture, but in what degree.

Touch as a communication tool is rather missing from the delegate nurses work for many reasons. One being the nature of the work and a second one the local culture were touch is avoided. Both touch and avoidance of it communicate things to the patient. The meaning of touch is not discussed further in the interviews, but could be a topic for later research.

Another form of communication is drawing, here an informant explains why this forms of communication is needed and gives an example of how you can use it:

> […] often you are missing the written communication totally. So, that you cannot give written care instructions, prescriptions, times, or… like anything. Because the other one has different alphabet […] than you or doesn't read at all. […] you have to come up with different means then, so then you draw a sun and 'then you take the medicine' and then you take the tablet. And a picture of moon, one [tablet] for the night. […] you define communication into new frames. (Interview C)

Communication has different frames in the field of humanitarian aid work of the nurses. Under this sub-heading different forms of communication that the nurses have used in the field have been presented. The lack of common language has pushed the nurses to use non-verbal communication and made them notice how important it is. An eye contact with the patient can have a great impact on the caring relationship, as demonstrated by the informants.

6.1.3 Listening

Communication is not only how you get your message through to the other person, but includes receiving messages from others as well. The skill of listening and how the fact that the patient feels that they are listened to affects the caring relationship according to the delegate nurses is discussed here.

An informant explained that the patients are usually nervous in the beginning, but when they start feeling that the nurse understands them, then they relax. In her opinion the way you act around patients is very important in this regard (Interview B). To show this she says that you need to "confirm the other human being", "really see them and to never judge… to try to understand." (Interview B) One of the ways to do this in her opinion is to listen to the other (Interview B).

Another informant elaborated on how you show that you are listening to the patient:

> […] you really let the patient talk. […] look at the eyes and ask are you meaning this or is it like that or… You really understand what the patient is saying. So, let the patient talk as much as the patient wants and… don't interrupt and look at the patient and look at the eyes. (Interview A)

According to the informant important is to look at the patient, ask follow up and clarifying questions and give time and space to the patient to talk. The same informant mentions an open discussion between the nurse and the patient, which in her opinion builds trust between them (Interview A). This trust then allows the patient to talk about also the "very very bad things [that have happened to them]" (Interview A).

Listening in this kind of caring context can be also seen as focusing on the facts and not the emotional level of caring as an informant explained after I asked what can make the caring relationship better in this context:

> […] if one is able to listen to the patient, if the patient is one that agrees [to give answers] […] That one doesn't go too much into […] the caring side, they might take it as not so positive even. But that you then, that you listen and then answer factually, explain, tell [what is being done]. (Interview F)

The informant here expresses that caring, the emotional kind, might not be preferred by the patients and that listening on the factual level only can be preferred by them. From the interviews the nurses highlight the patients need to be seen and respected, but when it comes to listening more important seems to be to be understood and given the space to talk freely.

6.2 Patient's choice

Under this heading the role of the patient in the caring relationship is presented from the point of view of the informants. Topics like patient's choice, expectations, wishes, gratitude and understanding regarding the care are analyzed.

6.2.1 "There is always a choice"

> […] often there are no options or if there are then you can't afford [them] […] So you have to like take what is offered. But then on the other hand patients decline care surprisingly often and turn to more traditional caring methods, healers and other […]. (Interview C)

As the informant above explained patients do decline care and find alternative options, even when it seems that the humanitarian healthcare that it offered is the only option available. There can be many reasons for choosing other methods of care or declining from the care completely as explained by the informant:

> […] something like amputation can be in another culture so incomprehensible taboo and so hard to consider and to decide that […] one can't accept it as an option and then declines from the care completely. […] in the end the patient has the power over what is done to them or not done.[…] even if there are no options, there is always freedom of choice. And their right to… decline […]. (Interview C)

What is highlighted by this informant is the power of the patient to decide on the care, even if it means that the patient is going to die if nothing is done. Even if in the humanitarian context the patient could be seen as being in such a situation that they have to take the offered care, the nurses must remember that the patient has always the choice not to take it. The informant continues on the power balance between the nurse and the patient and how it is different than it might seem at first:

> On the other hand, sometimes it feels like you don't have […] That you don't have any power over the patient. […] And you don't of course, but you could quickly think that in here you are… like God, but you are really not […]. (Interview C)

The humanitarian nurses and healthcare personal might get this feeling of being the savior, as in many contexts they are the only ones offering care. But as pointed out by the informant, the real power over the care is on the patient. Yet, as this was discussed by the informant so thoroughly, the power relation between the nurses and the patient is such that the nurses need to remind themselves that they are not the ones deciding on the care of the patient.

An informant described what she sees as the usual behavior by patient: "[…] basically patient is quite often like… 'biddable' […] But it doesn't mean that the caring relationship is good, if the other always submits to what is to be done to them." (Interview F) If the power balance is great and the other party, in this case the patient, obeys everything it affects greatly the caring relationship and not in a good way, as the informant explained.

The ethical dilemma on the decision of the care becomes even clearer on the following comment from an informant:

> […] it is like self-esteem and self-respect and we have to like accept it. And like who am I to say that 'your life is better with the amputation'. I can't know that. It can be lot worse than death. I can't decide it. (Interview C)

Working in another culture and in a foreign society, it is good to remember, as the informant pointed out, that the humanitarian nurse cannot always know what the life of the patient is going to be after the caring process.

Another informant elaborated on the circumstances in which the patient has to make the decision and what needs to be done by the healthcare personal to enable that decision:

> Also that everything is told to the patient, whether in the ward or in the operation theatre, what will be done and what is done next. […] So that the patient is always aware of what is to become, so that nothing comes as a surprise. […] so that the patient is like always taken with to the decision making. […] Not every patient is active and want to participate, but that the possibility is given. (Interview E)

Acknowledging the patient's right to a choice and giving the possibility to do so is a thing to be consider in the caring relationship. Here again the nurse's conduct has a great impact on the caring relationship and the empowerment of the patient.

6.2.2 Expectations and understanding of care

In many cases the patient's expectations of the care are met and patients in the humanitarian context are often very grateful as expressed by the informants. An informant sees the gratefulness as an emotional building block of the caring relationship (Interview D).

From the patient's expression of gratitude the nurse gets a feeling of satisfaction, that she has been able to help and this strengthens the bond of the caring relationship between the

nurse and the patient. Although, gratitude is often expressed by the patients and they seem to be grateful of the care they get, this does not exclude the high expectations they also have.

> […] in a way, although people are thankful, there are big expectations. They are thankful for everything, but on the other hand, the expectations are [great] […] for those who make it to the care […] they then hope for the miracle… like for themselves. […] your own expectations are big in a way, that we have a society [in Finland] which takes care of a person if they fall ill, but then there the person have to like… get to a condition that they can take care of themselves… and their family. (Interview C)

The circumstances where there is no follow up care and no societal safety net make both the patient and nurse's expectations of the care outcome greater, as explained by the informant.

What affects the expectations of the patient regarding their care in the humanitarian context? An informant shed light on the context:

> "And especially in the 'rural areas' people are really resourceful and they have a lot of traditional healing methods […] When they come to [a place] with foreign [staff] it has to be quite […] strong emergency. [Therefore] their expectations are quite high." (Interview D)

After their own resources have been exhausted they turn to the foreign aid, which then raises the expectations of the care. This screening of local resources is greatly different depending on the location.

> Those experiences from Africa are that patients are very receptive to all care what we offer […] What came upon in [a country in the Middle East] was that patients are well aware of their higher standards of healthcare […] In there the patients could come with a ready list: 'I want then a magnetic resonance image and then I want this and this fixation device and then I have to be fitting again in three weeks.' (Interview E)

It is not only the level of healthcare in the country or region, but also the micro level has a great impact on the care. What also affects the expectations is what the other patients get:

> […] then these food things, like if some patient is on a special diet because of some surgery and a big abdominal surgery has been done and he then gets different looking food than others. This might be experienced that he gets something better. These very practical things. (Interview E)

If the patient does not understand why the patient next to them gets treated differently they might think that their care is not as good as the others, as explained by the informant above. Understanding of the care and explaining why certain things are done becomes crucial for the caring relationship and trust between the patient and the nurse.

Expectations and understanding of the care can be very different between the humanitarian nurses and their patients. Communication here also becomes the key element of shortening the gap between them.

Another example was given by an informant on the different expectations on the care: “When the patients are not happy, if they get only tablets, then really easily injections are given. Over caring is really common.” (Interview F) Here can be seen how the different expectations can lead to unnecessary care that is not good for the patient. This is done to please the patient and keep them satisfied.

An informant referred as well to the level of education as being a hindrance for a good caring relationship (Interview D). When patients are uneducated and even illiterate that provides obstacles for good care (Interview F). This gap between the education level of the patient and the nurse, affects the caring relationship greatly. As the patient cannot discuss the care on a higher knowledge level and therefore might not understand what and why certain things are done. “[…] when they don’t know to demand, can’t speak for themselves, can’t converse. It lowers the quality of care.” (Interview F)

There are also patients that know exactly what they want:

> Some of the patients know very well what they want and if it is not available then it worsens [the caring relationship] or they want to [know] why, why this child’s […] bandages are not changed every day? And when you try to explain to the parents that it does not heal if you tear it open every day, but [they reply] “it is not good care if it is not treated every day”. (Interview C)

As shown under this sub-heading patient’s expectations of care vary depending on the local resources available, their level of understanding of care practices, what others around them get, for example. These all are broad topics and are only brought up superficially here, due to the limitations of this thesis. But what are shown here is what a great impact they have on the caring relationship.

6.3 Care taker

This sub-heading focuses on the role of family members, relatives, tribe elders, friends, neighbors and all the other people that are part of the patients’ caring process.

Here is looked into their role in the caring relationship, decision making process, as well as, the daily care routines.

In the humanitarian context the patient is seen often as someone needing help and having no resources on their own, but an informant described that resources can be found in the people around them (Interview A). Another informant put it even more bluntly:

> Patient is after all quite far an object… there. But who intervenes more on the care is quite often the care taker […] They are the one… well the one who speaks for the patient. Rarely the patient demands anything in there, they are passive quite far. Sounds terrible, but a passive object. (Interview F)

What the patient has in the difficult situation is a "care taker" as the informant calls them, who can be a family member, tribe member or any other person close to the patient. The care taker is seen by the informant as the spokesperson of the patient, (Interview F) as well as, as the previous informant put it the one that takes care of the patient (Interview A). These care takers can be found according to an informant almost in every place she has worked in and they are with the patient all the time (Interview F).

Having these care takers caring for the patient can have a huge impact on the care as explained by an informant:

> And then also the other way around, it can be something that you yourself see that nothing is coming out of the patient's recovery or care or rehabilitation that this has complications and it is difficult. Then suddenly the relatives are like gold and nurse the patient to recovery and then you can only be like "wow!" (Interview C)

Here can be seen the invaluable role of the care takers in the care of the patient. Still, it also brings challenges to the care and the work of the nurses: "How you can handle, when there comes people, there might come the whole family or whole clan and it is a big show and there are many factors… 'from the management point of view', that [whether] you [are able to] control that situation" (Interview D).

The caring relationship is not only between the nurse and the patient, but in these contexts all the people around the patient are included in it. As pointed by the informant above, it causes challenges to the nurse to manage the situation with so many people involved in it.

An informant explained her understanding of the situation: "[…] Quite far it is cultural, because the role of the family is really big, but it is also practical, because there are simply no assisting personnel." (Interview F) The role of the care taker in the daily care is discussed further under the following subheading.

6.3.1 Basic Care

Basic care is conducted by the care takers in many of the humanitarian contexts, as explained by an informant:

> And like in many countries it is like that the family, that nurses don't take care of the basic care, but the family does. Like feeding and toilet and shower and changing the sheets and the like. The nurses take care of the wounds and medications and operations and like entirely clinical, like medical care. The basic care is on the relatives. (Interview C)

The same understanding of the role of the care taker and the nurse in the caring process is shared by another informant, who continued that there would not be basic care if there were no care takers: "It would not work in fact at all, if there wasn't this, if there weren't care takers, who would take care of the basic needs." (Interview F).

The role of the care takers in the care of these patients is according to these informants seen as making sure that the basic needs of the patient are met. This distances the nurses from the basic needs of the patient and leaves only the clinical care to them in these contexts.

6.3.2 Deciding on the Care of the Patient

As already mentioned in the beginning of this sub-theme of care takers, they are often seen as the spokespersons of the patients. In fact, according to informants they are often the ones deciding on the care of the patients.

> There are cultures where the patient, where the patient doesn't decide themselves… if they are treated or not. Then parents are asked there and if parents are not alive, then a brother or the eldest brother or… mother's brother or… father's cousin. And sometimes that isn't enough, but the village elder [is asked]. And then they are fetched from around and sometimes further away and the patient's condition gets worse and two weeks are waited and [you are like:] "can't anyone come now and make this decision, that we could operate?" (Interview C)

When it comes to the decisions on the care the patient's own opinion and word seems not to matter much, if at all. Another informant shed light on the matter:

> Often is discussed with the patient of course, but never so that the care taker wouldn't be present. They always have to be present because otherwise often happens so that the decision has to be then taken back anyway. Sometimes happens, that it is needed to get more family… still to discuss on the matter. (Interview F)

Earlier in the interview the informant said that: "But direct interaction is always with the care taker." (Interview F) Although the patient is present in the discussion, the conversation might be only with the care taker. In some situations one care taker is not enough, but more people are needed to make a decision. The decisions of the care are seen as collective decisions, where the representative of the family or tribe are present.

It can also depend on the gender of the care taker whether more people are needed for the decision making process: "[…] patient is female and the care taker is female, then men are needed to acquire… to make those decisions. (Interview F)

The power of the care taker and other people around the patient is not only greater than the patient, but greater than anyone else's, including the medical personnel's. They can deny the care or decide to take the patient somewhere else to be treated, as explained by an informant (Interview E). Therefore the perception of the care taker on the care is crucial and also the "caring relationship" between the nurse and the care taker.

There are still situations, where it is not possible to have a care taker with the patient:

> But when we fetched wounded with airplane, from the bushes, then the families couldn't be with. Then the patient clearly needed much more support from us nurses and doctors, when s/he was totally alone there [in the hospital]. (Interview E)

Another situation were nurses need to take a bigger role in the care is explained by another informant: "Then there are those sad cases, when the care taker is an eight-year-old child, when there is no one else. Then it is a bit tricky. […] then the care personnel then just takes the responsibility." (Interview F)

The informants here have highlighted the role of the family, tribe, and other people who are close to the patient on the care and caring relationship. Although, there are situations where there are no one to make decisions on the care for the patient or to help with the basic care, more often a care taker seems to be present to do those things. In the contexts described by the informants the role of the people around the patient is crucial and

affects the caring relationship greatly. It is almost so that the caring relationship could be seen to develop between the care taker and the nurse, rather than with the patient and nurse in some cases.

6.4 Colleagues

In this sub-heading the focus is on the effect that colleagues have on the caring relationship. Colleagues in the context of humanitarian aid includes, according to the informants, delegate or expatriate colleagues, as they are called in different organizations and local colleagues. These colleagues can be other nurses or any other profession that is involved in the humanitarian work, like logisticians or administrational staff. First the work in multinational delegate teams is analyzed and then the relationship between local and international staff is discussed.

6.4.1 Multinational team

An informant sees multinational team as a source of knowledge (Interview A). Adding to the knowledge, in her opinion, was help that you get from your colleagues, as well as, friendships that form between colleagues. (Interview A)

She continued by emphasizing the importance of colleagues in the context of humanitarian work: “If there is a big problem with a patient you can […] ask someone else ‘what do you think about this and how are we going to do this now in the best way?’ […]” (Interview A).

According to another informant during the humanitarian missions the nurses are quite alone. She compared that in Finland the community at work is often bigger than the teams on the humanitarian missions. “[…] you have to then take big things, big decisions and there are no help available in the same way maybe as in the home country.” (Interview D).

The experiences of the informant nurses seem to be that the multinational team is a resource for knowledge and help, but often quite small, which might leave you without the support of a bigger community.

Another informant, who has been a delegate for the Red Cross for a long time, has noticed a change in the composition of the teams:

> You know, when I went the first time with […] the Finnish Red Cross, then it was drought in [a country in Africa] and we were five different teams; one Finnish team, one British, one Swedish, one Norwegian. And everybody worked with local people of course. But we didn't cooperate together. […] nowadays when I go out mostly I have gone alone. But last time when I was in [another country in Africa] […] we were four people living in house together. One from Indonesia, one from Nigeria, one from UK, and me. So, four different nations… who lived together. I think that's a… it's very good. Because if you put four Finnish people, then they stick together then… It's good that the teams are mixed. (Interview B)

Not only the nationalities are mixed, but the delegate team consists of many professions. An informant highlighted that. "what is extremely important there is the cooperation within the delegate team, which doesn't include only the healthcare personnel, but also logistics comes with as really important [part of it] […] (Interview E).

Team work is important according to the informants and is a resource for help and knowledge when it is multinational and multi-professional.

6.4.2 Local colleagues

The relationship between the local and delegate nurses was one topic that had a great impact on the caring relationship according to the informants. This will be discussed further here.

The delegate or expatriate nurses on the missions are not often the ones doing the day to day nursing. Therefore the cooperation with local staff is in a big role and crucial to the caring relationship.

An informant told about her first meeting with a local colleague in a country in African continent:

> So, I remember when I became to a clinic, the health assistant, he wasn't very happy to see me when I came there. And then I asked him something and what should we do? 'You decide you are the boss!'

> he told me. 'No, I'm not your boss. You are the boss and I'm your assistant.' And then he changed completely. (Interview B)

The relationship between the local staff and delegate nurses can be affected by the power imbalance that is seen to exist between them. But as seen above, the power balance can be switched or made more balanced by a single conversation.

An informant highlighted that it is important to have one representative of the local staff in every meeting and have weekly meetings together, were current problems and the current situation are discussed. She also added that this creates a feeling of togetherness with the local staff and a good ground for cooperation, as well as, trust on each other. (Interview E)

As the multinational team is seen to bring more knowledge into the work, local nurses and volunteers are seen in a similar way: "What is always a richness [is] to work with both local nurses and then that country's Red Cross volunteers." (Interview E)

The local staff can help to achieve the trust of the patients:

> […] you need to achieve the trust also in the eyes of the local colleagues. Well, it also comes by doing your work, but also on the personal level. And it is reflected in a way, the trust, also between patients and me. That if they see that the local nurses trust, respect and consult and are trusting, then also these patients are more trusting […]. (Interview C)

The respect for local and foreign nurses seems to vary in the eyes of the patients:

> […] often it is so that the patient doesn't want locals to do the caring […] if the countries own level healthcare has been low for a long time, then they are not trusted, but they want the only expat to do the caring. [Expat] who has seventy patients under them, to do everything themselves. And it is not possible. Then is needed to show with your own behavior respect and appreciation towards your own [local] colleagues and trust, so that the patient would… in a way trust as well. (Interview C)

In this way a trusting caring relationship can be born between a patient and a nurse, whoever the nurse is, a local or foreigner (Interview C). A contradicting view of the patients' trust on the local staff is presented by another informant (Interview F). In her opinion, local nurses are often valued and not always the patients want a foreigner, who does things differently, to care for them (Interview F). Still, she adds: "But it is valued greatly that we are there and see what takes place" (Interview F).

Although, the local customs would be appreciated by the patient more in some situations, these different actions by the local staff can create contradiction between them and the foreign staff (Interview F). The delegate healthcare professionals have to intervene if they see grave violations of their clinical guidelines by the local staff (Interview F).

The informants see that it is important to include the local staff in decision making and cooperate with them as much as possible, without an unbalanced power relationship. The relationship between the local and foreign nurses is seen to affect how the patients trust the nurses and their work as well. But this relationship between the nurses is affected also by the different roles the local and the foreign nurses have.

6.5 Delegate Nurse's Role

Here is discussed how the informants see the nurse's role in the caring relationship. Advising role of the delegate nurse, professionalism and distance caused by it, fluidity of the role due to gender and background as a foreign nurse as well as humor and play will be analyzed here.

6.5.1 Advising Role of the Delegate Nurse

The role of the delegate nurse is often an advising role, without much patient contact, as depicted by the informants. There are used different descriptions of the delegate nurse's role on the missions. An informant sees that her role, the role of delegate nurses, is not as often traditionally seen "nurturing, caring", but more like enabling and supporting (Interview C). Another informant sees the role of delegate nurses as coordinating and monitoring the standard of care, as well as, maintaining procedures and processes (Interview F).

The first informant sees the role of the delegate nurses as supporting the local staff in their work, when the second informant more as a supervising role. These two different views of the role of the delegate nurse create different relationships and power balances between the local and foreign nurses.

> […] It depends on the expat. If the person likes to train, advise and give instructions and does it in a way that is received like, that is received positively. There are those who have come there and feel that they have to show that they can do better. Then those [nurses] are not necessarily respected. Often

> our advice is followed as long as we are close by, but if there is no respect, that we are only respected because of our position, then it does not like come across. (Interview F)

The informant above sees the relationship depending on the persons, supporting the idea that different informants see the nurse's role differently. Different perceptions create different relationships. Not only the perception of the role but also the nurse's skills on training and sharing knowledge seem to make a great impact on the patient care. If the nurse's training is received positively it makes a change on the care procedures.

The training role of the delegate nurse is seen the most important by the informants:

> […] we surely do cooperate with local nurses and the whole healthcare personnel so that also teaching them and developing their skills in nursing is really important and is highlighted and it is […] one of our most important objects. That we go there to give that knowhow. (Interview E)

> In one of my mission I had two of those 'first mission', nurses on their first mission. […] They took strait away [a role] that now we manage and train […]. They probably did not have a lot of patient contact [during the mission], but they were really good. The standard of nursing, nurses rouse a lot there. […] foreign nurse, expat or delegate, who goes there to nurse the patients too much, then the actual work is left, in a way, undone. (Interview F)

The delegate nurses are not on the missions to do the patient care, but as highlighted by the informants above, the most important role is to share their knowhow. Still, it is dependent on the nurse's skills and perception of their role if they are able to do so.

The role of the delegate nurse on the mission depends also on the nurse's specialty. The two informants who are surgical nurses work with patients in the operating theatre, but also train local nurses. The other informants explained their work to be even more of the advising kind.

The delegate nurses do more training and advising than direct patient care. That is the perception given by the informants. When looking at the caring relationship between the delegate nurses and the patients on the missions, this is a factor that affects it greatly. The local nurses as well as the care takers are much more in contact with patients than the delegate nurses.

6.5.2 Professionalism

Professionalism was seen in different ways by the informants. An informant explained her attitude as follows:

> Actually, I see it like I'm professional, I am nurse […] Sometimes I can feel very sorry for them [patients]. But it can't take over because… then I'm not able to work with this kind of job. So, I always have to think of it in a professional way. That I have to keep the distance […]. (Interview A)

The informant above, saw the professional attitude and role of the nurse as a mental shield from the emotionally hard work. She sees that a distance between the nurse and the patient is needed to be able to nurse for patients in terrible situations.

Another informant saw a distance between the delegate nurse and the patient belong to the nature of the work. "It is a bit distant [the nurse's role] in the caring relationship, because I have only had one project where we foreign nurses really nursed the patients, where we have been on shifts, because there [a country in Africa] local workforce was not available." (Interview F) As the delegate nurses are not often the ones doing the direct nursing this leaves the caring relationship distant in her opinion.

She also sees that the delegate nurses are sometimes seen as "fussing", when they try to create some kind of a caring relationship with the patient. The local nurses often see their work as more technical; giving the medicines and caring for the wounds and then the job is done. (Interview F)

Another informant sees the delegate nurse's role as more flexible and caring. She expressed that even if in some cultures it is not typical to lull a child, it is easier for her as a foreigner to do so, and to take a warmer role in the caring relationship with a child patient.

> When you don't have to be like strict. And you can be little like… more playful and make jokes in the caring relationship […] you don't have to pretend to be some professional, when you come from Western countries and you come with the mandate of your organization, then everyone acknowledges you already. You are already with your presence a "kick-ass-professional". (Interview C)

In her opinion the foreign nurses are automatically acknowledged as professionals, which then gives them more freedom to foster a warmer caring relationship. An important tool for this meeting, when communication is limited, is the nurse's personality and humor. As the informant expressed above, a play can foster the caring relationship. When the

nurse is free to express the role and personality, tools like humor are easier to use. Still, as expressed by other informants under this category of nurse's role, in some contexts you might be more restricted expressing your personality.

Professionalism is seen very differently by these informants; one sees it as a coping tool, another as obstacle for caring relationship both culturally and technically, and the third one sees it as given for the foreign nurses, which then allows more flexibility in the caring relationship.

6.5.3 Flexibility in the role

The distance from the basic nursing duties was agreed to give more freedom to the delegate nurse's role in the caring relationship (Interview C). The informant continued how a trust needs to be built with more than the professional self:

> […] on my first mission was that there had not been white people at all, and the children were scared and ran away and cried when they saw someone with a white skin. Then you have to bring something totally else than the professional skills. (Interview C)

The informant acknowledges the need for other skills than the professional to create trust between the local population and the foreign nurses. She also talks about the difference between the roles of nurses and doctors, especially male doctors. "As a nurse it might be easier in a way […] when you think about doctors and especially male doctors, it [authority] is expected. […] as a nurse it is easier to cut the corners […]." (Interview C)

The role of male nurses was seen by the informant differently as well, although in her opinion differences in personality were more significant. "But maybe like for a woman it is easier to take little more relaxed role without losing your face and in a way it is more acceptable." (Interview C) Especially as a western woman, she feels, that you are put somewhere in the middle on the gender scale. Not being a woman in a culture that sees the female role stricter and not being a man either. "[…] you have more room to move on the [gender] scale and in a way take the best sides of both [female and male roles]." (Interview C)

Another informant relates to the issue differently, expressing more difference on the patients personal beliefs and experiences; what they know of the humanitarian work and its nature. In Muslim countries, she tells, that sometimes the patients became really demanding on the foreign healthcare personnel, as they felt that they have more to offer as foreigners. But then others closed into their shells and refused to discuss with the foreigners. She expressed a difference between the Muslim and African countries she had worked in; as in Africa she had danced with and hugged people. "There is like, what made it quite heavy also, that [Muslim] country was that you had to close a bit of yourself out, because you can't talk as much, you can't be that extrovert as we westerners often are." (Interview E)

Depending on the context, the country and culture, the role of the foreign nurse can be seen as more flexible or stricter, as expressed by the informants. What also affects the role of the nurse is how the profession is seen in the local society or community, as well as, the gender of the nurse.

6.6 Mental State and Violence

When looking at the caring relationship it is not only the current state of affairs that affects it. Informants see the mental package that both the nurses and the patients carry with them as an affecting factor. The humanitarian missions the delegate nurses work in are situated in places where people have faced catastrophes and conflicts. Physical traumas are accompanied with mental traumas in those places.

In this sub-chapter of trauma first the mental state of the delegate nurses' and its effect on the caring relationship is dwelled upon. Secondly, the effect of patient's mental state is presented. Thirdly, the mental environment of the society is discussed. The last part of this sub-chapter touches upon how violence in its different forms carries weight with the caring relationship.

6.6.1 Mental State

There has been talk about the delegate nurse's personality and skills in the previous parts of this chapter, but what is recognized by three informants is the mental state and mood of the nurse.

> […] actually I could add one thing that prevents [good caring relationship], one's own tiredness. Sometimes one notices, that when doing long days, comes a point when one can't give as a person what one should in that moment. Maybe not like such that it would have prevented the care or been a fatal thing, but one can't say that it does not have an effect. (Interview C)

Here the informant seems to talk about both the physical and mental energy and the lack of it. Another informant said it strait that it is the energy that the delegates bring with them to the missions that make the caring relationship better (Interview E). Still, the missions are demanding and an informant admitted that her organization is not able to provide enough psychological support for its delegates: "People have to work an awful lot with their own resources and own personality and some are able to keep on going and some not. (Interview D) Another informant explained her strategy of supporting her team: "try to keep up the good spirit in the team and to be in a good mood, that's also very important." (Interview A).

From these notes of the informants can be read that the missions are mentally and physically demanding. The support from the sending organization is not always there and the nurses have to lean on their team or as one of the informants pointed out blankly, just keep on going.

Coming with their energy the delegate nurses might not be able to empathize with the situation of the local colleagues.

> I remember that one western colleague criticized one local colleague as they rise from the bench so slowly when something needs to be done. […] Then I said that they have not gotten salary for a year and five months, but they are here, at workplace. How long would you work without salary? How many mornings would you show up… eager to work? (Interview C)

The informant continued that one can ruin a lot if not able to see the bigger picture. She referred to the situation that her colleagues are in and their story. If you judge people only by the actions you can see and not try to understand why they are doing so you can ruin the relationship. (Interview C) As discussed earlier in this chapter the relationship of the delegate nurses and local nurses has a great impact on the caring relationship with the

patients, hence it is important that the nurses, despite their different backgrounds would have the respect for each other that is seen by the informants to create grounds for good caring relationships.

Mental state of the patient has its effect on the caring relationship as well.

> I have been in war surgery, then there is always the mental trauma behind. […] possibly a fear of losing one's life and limb or something like that. Often the whole family has been in the same [situation]. Then there is worry about one's own family members. […] it is really loaded […] the caring relationship. (Interview C)

The situation as described by the shows the mental burden of the patients. Alongside the physical injury it is also the mental trauma that is part of the caring process. The same informant gives a good example of how the mental state of the patient impacts the care both in a good and bad way:

> Yes, it is really common. Stress and feeling inadequate and hopelessness and such on both sides. So the patient as well often feels [those things]. For example in one place we had a tent where were patients with spinal injury. Because it was the only place where it could be arranged, as it was a tent hospital and it was rainy season and mud and everything, that if was about to use wheelchair then they were put to this one place with an easy passage. But surely […] if you look that everyone, the whole tent is lying and getting bedsores and urinary infections and complications and others, then that can reinforce the hopelessness within the patient. […] But then the other way around as well. When one starts to walk then everyone is in rapture for a month, that 'we'll also rise from this.' Even though, it statistically does not sadly go so of course. […] Both patient's and one's own [nurse's] mental stress and state of being [affect the caring relationship]. (Interview C)

A little bit of hope can have a great effect on the patient and give positive energy into the caring relationship, sadly also the unfortunate faiths of other patients can also take hope away. It is not only the surrounding environment that is accredited to have an impact on the caring relationship by the informants. The resilience of the patients and people in general in the harsh conditions of conflict and disasters is expressed by an informant: "when people don't have an arm, don't have a leg, don't have an ear, don't have an eye. […] the person is being mutilated and the war and the conflict causes so much suffering to that other person and how these people are resilient in the middle of that terror." (Interview D).

The mental capacity and "energy", as the informants put it, of the patients and nurses affect the caring relationship both in positive and negative ways. The inner resources that those people have are tested in the harsh conditions of the humanitarian missions. What is expressed by an informant (interview C) is that not only the individual mental state of

people, but also the whole community's or even society's state has an impact. She talks about collective trauma that affects the local population (Interview C).

As an obstacle for good care is the amount of exposure to traumatic events as seen by the same informant: "[…] how the local population has been exposed to the conflict. How much there is capacity in a way. Sometimes there is more and sometimes there is none. It's a thing that I can't affect and they can't affect either." (Interview C). The prevailing mental state in the society is seen by this informant something that the nurses just have to accept, but its effect on caring relationship is acknowledged.

In here the analysis has touched upon the mental aspects of people affecting the caring relationship. The focus has been on mood of the delegate nurses as well as their energy level. A note on the lack of psychological support for the nurses by the organization was made by an informant. The informants quoted above see that it is mostly up to the nurses themselves to keep their mood up and take care of their mental survival. The patients' mental state was also discussed and the effect that environment and society has on them was highlighted.

6.6.2 Violence

Violence in many forms is being discussed by the informants. Whether it is targeted towards the staff or patients it is seen to affect the caring relationship. Here the forms of violence that are brought up by the informants are presented.

Violence by patients towards the staff, the nurses, affects the caring relationship. Working with traumatized people in unstable circumstances predispose the delegate nurses to violence (Interview C). Although, it can be experienced differently by different nurses. An informant points out that the female nurses might be experiencing more unpleasant caring relationships than their male colleagues (Interview C).

When patients turn to the care of humanitarian aid as a last resort, the expectations are high. "If we are not able to respond to the situation according to their expectations […].

There can come also these feelings of anger and aggressiveness." (Interview D) Frustration on unmet expectations and unstable circumstances as well as traumatized mind can make people to resort to violence.

The delegate nurses have to be prepared and think about their own security (Interview B). When the nurses can expect violence to occur sometimes and as they have to be alert and aware of their own security the caring relationship is shadowed by the fear of violence. "So, these kind of a working situations, I think, you must trust your own intuition." (Interview B). As the informant points out, the nurse has to read the situation and anticipate treats to their safety. This can undermine the development of a good caring relationship.

Violence amongst the patients is also a phenomenon which is brought up by an informant:

> Where the patient comes from, which military group or tribe they belong. And as we are a neutral organization, then we treat everyone equally and we don't have any limitations on who we receive. Then there are these sad situations that there has been from opposite tribes and then in the night time, when there is less nurses and we don't, rarely do night shifts, due to security reasons. […] Then sometimes there has been found a patient dead […]. (Interview E)

This kind of violence harms the caring relationship between the perpetrator and the nurse as well as it creates a hostile environment for the caring to take place.

The prevailing security situation is also named as a factor affecting the work of the nurses. Hence, it is not only the direct violence, violence on the personal level but also the violence happening in the surroundings. "[…] sometimes because of your own safety you can't do your work when it should be done. Or you have to leave in the middle of caring for a patient and leave the hospital and leave the patients there." (Interview C). She continues that when the next group of delegates return to the hospital the welcome from the patients is not that warm as they feel that they were abandoned (Interview C). This does not create a trustful base for the caring relationship.

Violence that targets local women has imprinted to the memory of two informants. The first informant tells how difficult it is for her, when a woman comes to the hospital and has been assaulted by her husband: "That's very very very difficult for me because sometimes they are really bad[ly] injured when they come to the hospital." (Interview A).

I asked if the husband is usually present in the caring process in these kinds of cases of domestic violence and the informant said that they usually are. Although, she seems to have a very hard time accepting the state of things she concluded: "But I have to when when I'm in this culture I have to accept it and I can't say anything to the husband, but this is maybe the most difficult thing." (Interview A) When the perpetrator of the violence is present in the caring process it causes ethical dilemma for the informant. When she cannot do anything about the situation outside the care of the injuries it is frustrating.

The second informant narrated a practice in an East African country that has stayed in her mind most strongly:

> [They] circumcised their girls by ninety percent, everything was taken away, labia and this small very small hole was left and great scar tissues. The suffering of these young mothers and the distress when the deliveries somehow happened or their distress was around three and six in the morning. And as they are so severely circumcised the deliveries are so difficult. That has stayed in mind most strongly, this life's, you know, cruelty. That these young women are mutilated and this one part of womanhood is taken away and they are raised in it, they have grown in it, that it is a part of it, that this is in a way normal part of their life. The great suffering. (Interview D)

The mind of the informant was affected strongly by her experiences among these circumcised women. The feeling and ethical issues raised in the mind of the informant have an effect on the caring relationship. She still feels strongly for those women and says that she has given many speeches and lectures on the issue on different occasions.

Violence has direct impact on the caring relationships between the delegate nurses and their patients. The nurses face threat of violence as well as direct violence on their missions from the patients. Also, violence amongst patients and in the surroundings have a great affect. Ethical issues arising from violent practices and domestic violence have a sting imprint on the nurses and their work.

7 DISCUSSION

The discussion in this chapter situates the main findings of the results in perspective with each other, the research question, the theoretical framework, as well as, previous research. A critical review of the cultural competence and transnational competence, caring relationship, and qualitative content analysis is presented. In the end of this chapter future research topics are explored.

Most prevalent themes in the interviews are presented first. Theme that was mentioned in every interview, in most one of the first things that affect caring relationship, was interpreters. Interpreters were seen important to achieve a certain level of communication. Still, what five of the informants expressed, was that the interpreters do not always translate correctly, either because they do not master the languages or because certain topics are taboos and they do not want to translate them. Hence, the biggest concern with interpreters is whether they are translating correctly.

Non-verbal communication was also mentioned in some form in every interview. Eye contact was mentioned in three interviews and was regarded as very important for caring relationship.

Themes that were mentioned in five interviews were patient's understanding of care and how it is seen to have an impact on the caring relationship, local colleagues ranging from trust between them and delegate nurses, their skill level and trust in them and their trust in the delegate nurses, advising role of the delegate nurses and how their work is more to oversee, train and coordinate than to nurse, and violence in different forms.

The most rarely occurring themes in the interviews were multinational team, basic care, "there is always a choice", and listening, which all were mentioned in three of the interviews. Multinational team was seen as a source of knowledge and support. Basic care was discussed in relation to the care takers performing it and their importance for the care of the patients. "There is always a choice" referred to the difficult situation of the patients, where it might seem that the care provided by the humanitarian professionals was the only choice, but in fact the patient has always the right to decline the care. Listening was

presented as an important part of communication and a way to gain the confidence of the patient.

Then the focus will turn to the research question and the relation to the results. The research question was: what factors affect the caring relationship between humanitarian aid nurses and their patients?

Factors affecting the caring relationship between the humanitarian nurses and their patients in the field the most are people, according to the informants of this research. Interpreters, who aid in communication, local colleagues, who do most of the nursing, care takers, who perform basic care and, in many cases, decide on the care of the patient, other patients, both in giving hope and taking it away. But what can be seen to have the greatest effect is the patient and nurse themselves, their understanding of the situation and the other, their skills and attitude.

Power-unbalance was seen as a problem and to purposefully give chances to the patient to express needs and wishes, and to include them better in the caring process was seen by the informants to contribute positively to the caring relationship. Still, this should be done without ousting the care takers.

Going back to the theoretical framework of this thesis; the concept of caring relationship and the relevance of cultural competence and transnational competence. The caring relationship as defined for this research underlines the cooperative nature of it. What can be seen in the research results this is the ideal that the informants also seek in their work by listening and respecting the choices of the patient. As the caring process is an open system by its nature, the surroundings have an effect on it. The results show that the other stakeholders are not merely surrounding the caring relationship but can be considered to be part of it.

Evaluating the multicultural environment's effect on the caring relationship, we turn to the theories of cultural competence and transnational competence. Cultural competence emphasizes knowledge of other cultures and transnational competence exchange of knowledge and personal abilities. Let us look first at the cultural competency in the light

of the data. The different concepts of cultural competency were: cultural awareness, cultural knowledge, cultural sensitivity, cultural competency, cultural encounter and cultural will.

Cultural awareness was present in the interviews in the form of patients' beliefs and understanding of care for instance. Informants recognized the need to be aware of the patient's culture as it was seen to affect the care decisions. The health inequalities included under cultural knowledge, or more the inequalities on healthcare were clearly recognized to affect the caring relationship. Informants saw clear differences and similarities on their and patients' cultures and demonstrated cultural knowledge in the interviews. Cultural sensitivity was shown in the interviews through cooperation with care takers and appreciating the existing practices on decision making. Informants valued communication and interaction skills, and their use to bring patient's view of their situation in front, which shows cultural competency. Informants pointed out that meeting the patient as individual is important not merely product of their culture, which is the main idea of cultural encounter. Motivation and genuine interest to help the patients, knowns as cultural will, was clear in the interviews.

Cultural competency model seems to fit the data and support the informants' understanding of the affecting factors on the caring relationship between them and their patients in this context. However, the order of which should come first, knowledge or skills is questioned. Although, some primary knowledge about particular culture is seen to be valued, personal and professional skills of the nurses are much more highlighted in the interviews to contribute to the caring relationship. Here we turn to transnational competence.

The dimensions of transnational competence are: analytical, emotional, creative/imaginative, communicative, and functional competence. Analytical competence is relevant when looking at the issues related to patient's choice. This competence is needed to be able to understand the patient's care choices and understanding of the care. Also, the role of the care taker in the care process can be understood with analytical competency. The mental state of the individual, local, and national level asks for analytical competency as well. Emotional competency asks for motivation and sensitivity towards others' experi-

ences, which can be seen very relevant in relation to the interviews. As the people involved in the caring relationship, be it the care taker or a local colleague, are greatly affecting it the skill to read emotional messages becomes crucial, as the ability to respond to them in a correct way. Creative/imaginative competence, the ability to exploit the synergistic potential of diverse groups, in the context of this study including multinational teams, local and delegate nurse teams, translator and nurse team and so forth, is highlighted. The problematic dynamics of those groups/teams is in the center of the interviews and therefore the ability to mutual problem solving is highly valued. Communicative competency and its relevancy for this study becomes clear in the communication section of the results. Communications skills and their imaginative use is contributing to a good caring relationship. When looking at the caring relationship not only the encounter itself is relevant, but the building of and maintenance of a positive relationship. Functional competence in its entirety becomes crucial for the caring relationship. The ability to relate to the other stakeholders, as well as, overcome problems in the micro and macro level hindering the caring relationship.

Transnational competence does not have its focus on specific features of the context, but rather on the specific skills of the persons involved. It asks for very high skill set that is not always found neither on the healthcare professionals nor on the patients or care takers. Still, the relevance of these competencies is clear and should be seen as something to strive towards and to support in others.

From the theoretical discussion we turn to earlier research and its relation to the results of this study. This study is in line with earlier studies (Dorell and Jonsson 2010) only with different emphasis. Things that were not regarded to be important in the interviews done for this research, in contrast to earlier research, was nurse's relatives for the nurse's work (see (Dorell and Jonsson 2010: 11). However, the most important difference between earlier research and the results presented in this thesis is the importance of patient's and care taker's role, as well as, the role of other people (see Dorell and Jonsson 2010). Earlier research touches upon the deciding role of care takers as deciding for the patient (see Dorell and Jonsson 2010: 8) and patient's gratitude towards the nurses (see Dorell and Jonsson 2010: 12-13), but the focus of the analysis stays quite strictly on the nurse's importance for the patient encounter.

As the earlier research set out to investigate nurse's point of view of the patient encounter, the conclusions ended up highlighting how the nurses affect the encounter and what affects the nurses in that context (Dorell and Jonsson 2010). This present study continued from that and shows the role of other stakeholders for the caring relationship. Although, very similar findings are presented in both these studies, this study tries to focus on more broadly on the caring relationship than on the effects the nurse has on it.

A relevant discussion regarding the integrity of the results of this research is the representativity of the informants of the humanitarian aid nurses as a group. As the convenience sampling was used in this research, the representativity of the informants for the whole group can be questioned. All the informants are women, which leaves out the male nurse perspective. The informants have work for different organizations and are of different age and different specialization within nursing profession. Still, the results from the different interviews are congruent, which would then suggest that they are quite representative of the Finnish humanitarian aid nurse's perspective. The issue of gender is brought up in the interviews as having an effect on the caring relationship and therefore a male perspective could present other results. This topic will be left for future research.

The theories or methods used in this thesis have faced criticism, which will be discussed here. Katie Eriksson has received critique on her work mostly because her methodological approach has been difficult to understand (Grönroos, Lindholm, and Lindström 1994: 510). Her theory is easy to understand on a general level, but some new concepts that she has introduced are not completely generally accepted in caring science (Grönroos, Lindholm, and Lindström 1994: 510-11). Also, her concepts, like the caring relationship, have not received a clear form yet, which make her theory unclear in some instances (Grönroos, Lindholm, and Lindström 1994: 510).

Critic towards cultural competence points out that the model does not see the real differences between cultures, social inequalities, or negative attitudes within healthcare settings (Sainola-Rodriguez 2009: 51-52). When focusing on knowledge and not on the personal abilities, it is easy to consider culture as a stereotype (Wikberg 2014: 46) and not as a

social concept towards which everyone relates differently. Therefore, a healthcare professional can make the mistake to meet someone as a representative of their cultural background and not as an individual.

Transnational competence can maybe offer a model where patient is seen as a more important actor than the professional. The individual abilities of the parties are more important than general knowledge on culture to achieve good care results. The complexity of the relationships of the multicultural environment of humanitarian aid set a challenge to even a very transnationally competent person. With the numerous stakeholders, power-imbalance, and obstacles of communication the focus on skills not knowledge comes apparent.

Content analysis has received critique as a method from both quantitative and qualitative field, where the former does not consider it to be detailed enough for statistical analysis, and the latter too simplistic for the nature of qualitative analysis (Elo and Kyngäs 2008: 108). Any research method can result to simplistic results or detailed analysis, depending on the skills of the researcher (Elo and Kyngäs 2008: 108). Content analysis is widely used in nursing research, despite the criticism, as its benefits are content-sensitivity and flexibility in research design (Elo and Kyngäs 2008: 108). These were also the reasons behind the choice to use content analysis in this research.

A future research topic that rose from the first interviews and was mean tined by the last informant as well, is the relationship between the delegate and local nurses and other staff as well. This topic was briefly presented in the results chapter under heading Colleagues, but further investigation is needed to be able to see its effects on the work of the delegate nurses, the caring relationship, and humanitarian aid in general. Also, the importance for the local community, healthcare, as well as, professional and personal development could be studied in relation of the local/national staff and humanitarian aid.

8 CONCLUSION

This chapter presents the concluding thoughts and key points of this thesis. The current state of research lacks deeper analysis of the caring relationship between humanitarian aid nurses and their patients on the humanitarian missions. Focus in Finnish and Swedish academic literature, as well as, publications in English language focus mainly on the humanitarian nurses' experiences and professional acquirements. Also, few studies focus on ethics in the field. This thesis tried to fill some part of that research gap. The data gathered for this research included six semi-structured interviews with humanitarian aid nurses, where their understanding and view on the factors affecting the caring relationship were explored.

Earlier research focused on the encounter on the field between humanitarian aid nurses and patients (Dorell and Jonsson 2010). The analysis has its focus on the nurse; nurse's responsibility of the encounter (Dorell and Jonsson 2010). The nurse's effect on the encounter and what affects the nurse are the key points of the earlier research (Dorell and Jonsson 2010). This thesis, on the other hand, highlights the role of other stakeholders and how they should be seen as part of the caring relationship; the interpreters and the various problems of using them, the care takers and their role on the decision making, local colleagues, who are actually doing most of the nursing.

The responsibility of the relationship is on the nurse, which in the context of humanitarian aid is both a local and delegate nurse, and the patient and their understanding, attitudes, and skills has the greatest impact on the caring relationship. Still, the care takers have a crucial role in the caring process and are part of the caring relationship. The skills of the persons involved are in the theoretical focus, not specific knowledge on the situation. Analytical, emotional, creative, communicative and functional competencies are asked from the involved parties.

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APPENDICES

Appendix 1. MESSAGE SENT THROUGH THE FINNISH RED CROSS TO THEIR DELEGATE NURSES

Dear Finnish Red Cross Delegates,

I am a third year nursing student from Arcada University of Applied Sciences. I am looking to interview nurses who have been on one or more missions.

Based on the interviews an understanding of humanitarian nurses on the caring relationship between them and their patients on missions is developed. The wider aim of the research is to explore the caring relationship between humanitarian nurses and their patients and factors that influence it. This kind of viewpoint is not strongly visible in academia and therefore I try to bring it up.

Every interviewee is interviewed once and the duration of the interview is about an hour. The interview will be recorded. The interview will be conducted in a calm place suitable for the interviewee in the Capital Area or via Skype. Interviews are conducted early summer and the research is due to be finished this autumn. If you are interested in participating in the research send me an email or call me and I will give you more information.

I would greatly appreciate your help to realize my research.

Summer greetings,
Kukka Nuora

Hyvä Punaisen Ristin delegaatti,

Olen kolmannen vuoden sairaanhoitajaopiskelija Ammattikorkeakoulu Arcadasta. Etsin opinnäytetyötäni varten haastateltaviksi sairaanhoitajia, jotka ovat olleet yhdellä tai useammalla komennuksella.

Haastattelujen pohjalta on tarkoitus ymmärtää humanitaarista työtä tehneiden sairaanhoitajien käsitystä hoitosuhteesta heidän ja heidän potilaidensa välillä komennuksilla. Tutkimukseni kartoittaa laajemmin humanitaarista työtä tekevien sairaanhoitajien ja heidän potilaidensa välistä hoitosuhdetta ja siihen vaikuttavia tekijöitä. Tällainen näkökulma ei ole vahvasti esillä akateemisessa tutkimuksessa ja sitä yritänkin tuoda esiin.

Jokaista haastateltavaa haastatellaan kerran ja haastattelu kestää noin tunnin. Haastattelu nauhoitetaan. Haastattelu toteutetaan haastateltavalle sopivassa rauhallisessa paikassa pääkaupunkiseudulla tai Skypen kautta. Haastattelut on tarkoitus toteuttaa alkukesän aikana ja tutkimuksen on määrä valmistua tänä syksynä. Jos kiinnostuit osallistumisesta tutkimukseen lähetä minulle sähköpostia tai soita ja annan lisätietoja.

Arvostaisin suuresti apuasi tutkimukseni toteuttamisessa.

Kesäisin terveisin
Kukka Nuora

Appendix 2. CONSENT FORM IN ENGLISH

Arcada University of Applied Sciences
Department of Health and Welfare
Nursing programme
Consent form

Caring Relationship between humanitarian aid nurses and their patients

BRIEFING FOR INFORMANT AND CONSENT FORM TO TAKE PART IN THE STUDY

Researcher/Student:
Kukka Nuora
Nursing student

Supervisor:
Gun-Britt Lejonqvist
Degree Programme Director, Principal Lecturer in Global Health Care

Background Information
This research is Bachelor's Thesis in Nursing programme at the Department of Health and Welfare in Arcada University of Applied Sciences. Supervisor of the thesis is Gun-Britt Lejonqvist from the Department of Health and Welfare. The interviews for the research will be conducted during spring and summer 2018 and the research is due to be finished autumn 2018.

How the research data is handled
The researcher is responsible for the safe handling and storing of the data. Manual data will be stored in a place where only the researcher has access to, also all the electronic data will be stored in a computer to which only the researcher has access. The researcher

is the only one that can connect the informants personal details and the interview data. In other words, personal data and the interview material is stored separately.

The purpose, aim, and meaning of the study

The purpose of the study is to explore the understanding that nurses, who have done humanitarian work, have on the caring relationship between them and their patients on the missions. Based on the interviews a qualitative study on the factors that affect the caring relationship between the humanitarian nurses and their patients will be conducted. This kind of viewpoint is not strongly visible in academia and therefore this study tries to bring it up. Previous research has focused on nurses experiences on the demands of humanitarian work and the professional skills required.

Methods of the study that will be applied to the informants

The study is based on interviews and there will be one interview with each informant. Interview method applied is semi-structured, which is based on pre-prepared open-ended questions. The duration of the interviews will vary, the estimated time being an hour. The interviews will be tape recorded.

The interviews will be conducted in a place that is convenient for the informant, for example the informants home or tranquil public place.

How and to what will the research data be used for

The data collected in the research will be used only for the researcher's Bachelor's thesis.

The rights of the informant

Taking part in the study is completely voluntary and the informant has full right to decline form the research, and also to quit the study at any stage of it, without there being any consequences to them. In such a case the data that has been already collected will not be used in the study. The data collected is only for the use of the researcher and the results will be published only in the researcher's Bachelor's thesis, so that individual participants

are made anonymous. Informant will be most likely able to point out references to themselves. Informants have the right to ask and to get more information about the study at any stage of it, both from the researcher and from her supervisor.

Consent of the informant

I have read through and understood the purpose of this study and its content, its meaning for me as participant, and my rights as informant. I give my consent to take part in the study and the interviews. I promise to inform the researcher if my physical or mental health does not allow me to participate or if I change my mind and want to quit the study. So, if I want to I can quit or cancel my participation in any stage of the study. The data collected from my interviews can be used in the Bachelor's thesis of the researcher in a form where it has been made anonymous.

Date_____ Informant's signature_____

Date_____ Researcher's signature_____

Appendix 3. CONSENT FORM IN FINNISH

Ammattikorkeakoulu Arcada
Terveyden ja hyvinvoinnin instituutti
Nursing koulutusohjelma
Suostumuslomake

Hoitosuhde humanitaarista työtä tekevien sairaanhoitajien ja heidän potilaidensa välillä

TIEDOTE HAASTATELTAVALLE JA SUOSTUMUS OSALLISTUMISESTA TUTKIMUKSEEN

Tutkija/Opiskelija:
Kukka Nuora
Sairaanhoitajaopiskelija

Ohjaaja:
Gun-Britt Lejonqvist
Examensansvarig överlärare i vård (sjukskötare/global health care)

Tutkimuksen taustatiedot
Tukimus on Nursing koulutusohjelman opinnäytetyö, joka on Ammattikorkeakoulu Arcadan terveyden ja hyvinvoinnin instituutin alla. Opinnäytetyön ohjaajana toimii Gun-Britt Lejonqvist Terveyden ja hyvinvoinnin laitoksesta. Haastattelut tutkimusta varten toteutetaan kevään ja kesän aikana 2018 ja tutkimuksen on määrä valmistua syksyllä 2018.

Tutkimusaineiston säilyttäminen
Tutkija vastaa tutkimusaineiston turvallisesta säilytyksestä. Manuaalinen aineisto säilytetään niin, että vain tutkijalla on pääsy siihen, samoin kaikki materiaali, joka on kerätty elektronisesti säilytetään tietokoneella, johon vain tutkijalla on pääsy. Henkilötiedot ja aineisto siis säilytetään erillään niin, että vain tutkija pystyy yhdistämään ne toisiinsa.

Tutkimuksen tarkoitus, tavoite ja merkitys

Tutkimuksen tarkoitus on kartoittaa humanitaarista työtä tehneiden sairaanhoitajien käsitystä hoitosuhteesta heidän ja heidän potilaidensa välillä komennuksilla. Haastatteluiden pohjalta tutkitaan laajemmin humanitaarista työtä tekevien sairaanhoitajien ja heidän potilaidensa välistä hoitosuhdetta ja siihen vaikuttavia tekijöitä. Tällainen näkökulma ei ole vahvasti esillä akateemisessa tutkimuksessa ja sitä yritetäänkin tuoda esiin tällä tutkimuksella. Aikaisemmat tutkimukset ovat keskittyneet sairaanhoitajien kokemuksiin humanitaarisen työn vaatimuksista, sekä ammatillisiin vaatimuksiin.

Tutkimuksen menetelmät, joita sovelletaan osallistujiin

Tutkimus perustuu haastatteluihin, joita on kutakin haastateltavaa kohden yksi. Metodina on puolistrukturoitu haastattelu, joka perustuu ennaltalaadittuihin avoimiin kysymyksiin. Kestoltaan haastattelut vaihtelevat, arvoitu kesto on noin tunnin. Haastattelut nauhoitetaan.

Haastattelut toteutetaan haastateltavalle parhaiten sopivassa paikassa, esimerkiksi haastateltavan kotona tai rauhallisessa yleisessä paikassa.

Miten ja mihin tutkimusaineistoa aiotaan käyttää

Tutkimusaineistoa käytetään tutkijan opinnäytetyössä ja ovat vain sitä varten.

Tutkittavan oikeudet

Osallistuminen tutkimukseen on täysin vapaaehtoista ja tutkimukseen osallistuvalla on täysi oikeus kieltäytyä tutkimukesta, sekä keskeyttää se missä tahansa tutkimuksen vaiheessa, ilman, että siitä aiheutuu mitään seuraamuksia. Tällaisessa tapauksessa jo kerättyä materiaalia ei käytetä tutkimuksessa. Tutkimuksesta saatava aineisto on vain tutkijan käyttöön ja tulokset julkaistaan opinnäytetyössä siten, että yksittäinen osallistuja on anonyymi. Osallistuja kuitenkin tunnistaa varmasti viittaukset itseensä. Tutkimukseen osallistuvalla on myös oikeus kysyä ja saada lisätietoa tutkimuksesta missä tahansa vaiheessa tutkimusta tutkijalta tai hänen ohjaajaltaan.

Tutkimukseen osallistujan suostumus

Olen perehtynyt tämän tutkimuksen tarkoitukseen ja sisältöön, siihen osallistumisen merkitykseen minulle sekä oikeuksiini siihen osallistujana. Suostun osallistumaan tutkimukseen ja haastatteluihin. Ilmoitan, jos henkinen tai fyysinen kuntoni estää osallistumasta tutkimukseen tai jos muutan mieleni tutkimukseen osallistumisesta. Voin siis halutessani keskeyttää tai peruuttaa osallistumiseni tutkimukseen tai kieltäytyä tulevista haastatteluista missä vaiheessa tahansa. Haastattelustani kerättyä aineistoa saa käyttää tutkijan opinnäytetyössä sellaisessa muodossa, jossa olen anonyymi.

Päiväys_____ Osallistujan allekirjoitus_____

Päiväys_____ Tutkijan allekirjoitus_____

Appendix 4. INTERVIEW GUIDE

Hoitosuhde humanitaarista työtä tekevien sairaanhoitajien ja heidän potilaidensa välillä - Caring Relationship between humanitarian aid nurses and their patients

Haastattelukysymykset sairaanhoitajille - Interview questions for the nurses:

Taustakysymyksiä/Background questions:
Kuinka monella komennuksella olet ollut Punaisen Ristin kautta?/ How many missions have you done (for the Red Cross/other organization)?

Interview questions:

Kuvaile "tyypillinen" kohtaaminen potilaan kanssa kentällä. / Describe a "typical" encounter with a patient in the field.

Millaisena näet hoitosuhteen tässä kontekstissa?/ How do you see the caring relationship in this context?
Millaisena näet oman roolisi hoitosuhteessa? / How do you see your own role in the caring relationship?
Millaisena näet potilaan roolin hoitosuhteessa? / How do you see the patient's role in the caring relationship?
Mitkä muut tekijät vaikuttavat mielestäsi hoitosuhteeseen ja miten? / What other factors affect the caring relationship in your opinion and how?
Mitkä asiat estävät hyvän hoitosuhteen rakentumista? / What factors hinder a good caring relationship?
Mitkä asiat edistävät hyvän hoitosuhteen rakentumista? / What factors foster a good caring relationship?