Unaccompanied Minor Asylum Seekers’ Health Promotion in a Reception Center
Recommendations for Good Practice

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Laurea University of Applied Science **Abstract**
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In the 2000's there was an increase in the number of asylum seekers in Finland. A particular, vulnerable group within the asylum seeker population is those minors who arrive without their family. Although according to Finnish Integration Act, unaccompanied minor asylum seekers have nearly equal access to health care services with the national population, some legislation-based restrictions exist. Asylum seekers have had traumatizing experiences and possibly lacking health care in their past. Also insecure future prospects cause distress. Therefore health promoting practices of daily work have an important role to support the minors' well-being.

The purpose was to study how professionals promoted unaccompanied minor asylum seekers' health in their daily work in a reception center. Secondly, what were the methods and thirdly what was the content of health promotion. Lastly, the purpose was to establish recommendations for good practices. Action research method was applied. Data was collected from four professionals of a reception center through thematic interviews. Qualitative inductive content analysis method was used. Further, participants' collaborative feedback was used to refine the recommendations for good practices.

Findings consisted of reception a reception center's professionals' daily functions that aimed to support minor asylum seekers' health. The findings are depicted in four categories: emotional support, guidance, services and multi-professional co-operation. One category focuses on recommendations for improving the minors' care, in particular related to availability and quality of mental health care.

Recommendations for good practices that promote unaccompanied minor asylum seekers' health are presented as an outcome of this study. In addition, suggestions for future developments are expressed. A good practice is functional, effective, evaluated, ethically acceptable, based on versatile knowledge and concisely described.

Although reception centers in Finland differ to some extent and these recommendations cannot be generalized, they can be adapted in reception center work. To further develop recommendations for good practice, implementation and evaluation of these recommendations is needed. Also the clients' perspective should be included.

Keywords Good practices, health promotion, reception centre, unaccompanied minor asylum seeker

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Yksintulleiden alaikäisten turvapaikanhakijoiden terveyden edistäminen vastaanottokeskuksessa. Suosituksia hyviksi käyntänteiksi.

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2000-luvulla turvapaikanhakijoiden määrä lisääntyi Suomessa. Erityinen, haavoittuvassa asemassa oleva ryhmä turvapaikanhakijoiden joukossa ovat alaikäiset, jotka saapuvat ilman perhettään. Vaikkakin yksintulleilla alaikäisillä turvapaikanhakijoilla on Kotouttamislain mukaan lähes samat oikeudet terveydenhoitopalveluihin, joitakin lakisääteisiä rajoituksia on. Lisäksi heillä on traumatisoivia kokemuksia ja mahdollisesti puutteellinen terveydenhoito menneisyydessä eikä varmoja tulevaisuuden näkymiä, nämä seikat aiheuttavat ahdinkoa. Tämän vuoksi käytänteillä, jotka päivittäisessä työssä edistävät terveyttä on tärkeä rooli alaikäisten hyvinvoinnin tukemisessa.

Opinnäytetyön tarkoituksena oli tutkia, miten ammattilaiset edistivät yksintulleiden alaikäisten turvapaikanhakijoiden terveyttä päivittäisessä työssään vastaanottokeskuksessa. Toisekseen, mitkä olivat terveydenedistämisen metodit ja kolmanneksi, mikä oli terveyden edistämisen sisältö. Viimeiseksi tavoitteeksi oli luoda suositukset hyviksi käytänteiksi. Toimintatutkimusmenetelmää sovellettiin, neljää vastaanottokeskuksen työntekijää haastateltiin teemahaastatten metodein. Aineiston analyysissa käytettiin laadullista induktiivista sisällönanalyysiä. Lisäksi tutkimuksen osallistujien palautetta käytettiin hyvien käytänteiden suositusten kehittämiseksi.

Tulokset koostuivat neljästä päivittäisen työn toiminnoista, jotka tähtäsivät alaikäisten turvapaikanhakijoiden terveyden tukemiseen. Tulokset kuvataan neljässä kategoriassa: henkinen tuki, neuvonta, palvelut ja moniammatillinen yhteistyö. Yksi kategoria keskittyy suosituksiin alaikäisten hoidon parantamiseen, erityisesti liittyen mielenterveyshoidon saatavuuteen ja laatuun.

Tämän tutkimuksen tuotoksena esitellään suositukset alaikäisten turvapaikanhakijoiden terveyden edistämisen hyviksi käytänteiksi. Lisäksi tuodaan esille kehittämisehdotuksia tulevaisuudelle. Hyvät käytänteet ovat toimivia, tehokkaita, arvioituja, eettisesti hyväksyttäviä, perustuvat monipuoliseen tietoon ja ne ovat kuvattu tiivisti.

Vaikkakin eri vastaanottokeskukset poikkeavat toisistaan joltain osin eikä suosituksia voi yleistää, voi niitä soveltaa vastaanottokeskustyössä. Jotta suosituksia hyviksi käytänteiksi voisi edelleen kehittää, pitäisi ne toteuttaa käytännössä ja arvioida. Myös asiakkaiden näkökulman pitäisi sisältyä tutkimukseen.

Asiasanat Hyvät käytänteet, terveyden edistäminen, vastaanottokeskus, yksintullut alaikäinen turvapaikanhakija

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1 INTRODUCTION

The number of asylum seekers in Finland has in turns decreased and risen during the past three decades. According to the statistics, in the 1990's the annual range of asylum seekers was roughly between 700 and 3500. In the years 2000 to 2007 there were between 1500 and 3800 asylum applicants. In 2008 and 2009 there has again been a growth since the more quiet years of early 2000's, respectively 4035 and 5988 applicants, the latter being a record year (see TABLE 1, p. 7). In particular, there have been more unaccompanied minors than before, 706 in 2008 and 557 in 2009, in 2010 the amount dropped again to 329 (see TABLE 2, p. 9). Around three quarters of minor asylum seekers originated from Somalia, Iraq and Afghanistan in recent years (see TABLE 2). In order to respond to increased accommodation needs, more reception centers were established and some expanded during the years 2008 and 2009 (Ministry of Interior 2011a & 2011b).

In comparison with the population residing permanently in Finland, asylum seekers have a restricted access to health care services. According to the Finnish Integration Act, asylum seekers are entitled to services in case of essential need of care, however special needs are required to be taken into consideration (Laki maahanmuuttajien kotouttamisesta ja turvapaikanhakijoiden vastaanotosta §19). Minor asylum seekers have nearly equivalent rights in comparison with the national population, however, availability and specialization of some services, such as mental health care is inadequate (Helander & Mikkonen 2002, Sourander 2007, Parsons 2009). Thereby, daily care has an even more significant role in maintaining one's wellbeing than for those who have full access to health care.

Asylum seekers have often had traumatizing experiences in their past and have no secure future prospective, as they do not yet know whether they will be deported or granted residence in Finland. The majority of applicants come to Finland from countries or conditions where health care services may have been out of their reach. These life circumstances may be sources of stress and emphasize the need for an environment promoting health.

In this study it was aimed to find out, how a reception center's workers promote asylum seekers' health in their daily work, what are the methods and content of health promotion. Health can be promoted in daily work and it is not up to only clinical health care workers but all who encounter asylum seekers in their duties. Through the participation of a reception centers professional's, recommendations for existing good practice were established and proposals for future developments listed.

Action research method was applied; it emphasized the role of participants as active parties. Staff members were interviewed in an institution that housed mainly under aged asylum seekers. Participants gave collaborative feedback to refine the study's findings after the initial data analysis and refined recommendations for good practices are the outcome of this study.

TABLE 1. All asylum seekers and minor asylum seekers in Finland 2000-2010
(Finnish Migration Service 2011c)

Year	All asylum seekers	Unaccompanied minor asylum seekers
2000	2170	88
2001	1861	24
2002	3442	70
2003	3281	110
2004	3381	76
2005	2674	212
2006	2324	102
2007	1606	88
2008	4038	708
2009	6922	667
2010	4012	329

2 UNACCOMPAINED MINOR ASYLUM SEEKERS AND RECEPTION CENTER

2.1 Unaccompanied minor asylum seekers

According to United Nations Commission on Human Rights (UNCHR) an asylum seeker is a person "who has left their country of origin, has applied for recognition as a refugee in another country, and is awaiting a decision on their application" (UNCHR 2010a). An unaccompanied adolescent or a young person is someone under the age of 18, who is separated from both parents and not being cared by an adult who by the law or custom has responsibility to do so (UNHCR 2010a).

Foundations for regulations and policy concerning asylum seekers in Finland originate firstly from international treaties such as United Nation's Universal declaration of Human rights from the year 1948 and European Convention on Human Rights (1953). Secondly, European

Union immigration and asylum legislation as well as national legislation guide-line their process and life circumstances during their process in Finland.

Application for asylum must be submitted at the boarder of the country or at a police station shortly after arrival and asylum process starts after police or border control officials receive the application (Ulkomaalaislaki, § 95). An asylum seeker will be accommodated in a reception center for free of charge until his or her application decision period, if the applicant refuses accommodation, he or she can organize and finance it independently (Penttilä 1997).

Depending on to which official asylum the application was submitted to, border officials or police will investigate an asylum seekers identity, how the person entered to Finland and which was the route for travelling. Further, Finnish Migration Service will investigate the actual grounds for granting asylum, thus the events and other reasons for which a person should be afraid of being persecuted in her country of origin or residence. Migration office will issue the first residence permit. Asylum seekers have the right to use a legal advisor (Ulkomaalaislaki, Chapter, § 97) and to contact refugee organizations such as UNCHR or "Pakolaisapu" Finnish refugee council in Finland, in all stages of the process. In May 2011, the average waiting time for Finnish Migration Office's interview was roughly six months, on average a decision was received after ten or eleven months of additional waiting time (Finnish Migration Service 2011a).

If a person receives a negative decision, she/he has the right to appeal to Administrative court within 30 days, if further negative decision is given, a person can apply for a permission to appeal to Supreme Administrative Court (Refugee Advice Centre 2010). Asylum seekers also have the right to appeal to European Court of Human Rights. This international court's rulings are based on European Convention on Human Rights (European Court on Human Rights 2010). If all these steps need to be taken, an individual's process will consume significantly more time than the average procedure time depicted by Finnish Migration Service. After receiving a residence permit based on the right for asylum or protection on the basis of humanitarian grounds, a residence in a Finnish municipality will be addressed. At the moment, there is a lack of municipalities and residential facilities offered to refugees in Finland prolonging people's process even further (Valtakunnallinen pakoalaisten kuntiin osoittamisen strategia 2010-2011).

Member states of European Community have been determined as safe countries (European Union Council Regulation 343/2003, (2). Thereby, if a person has entered the territory of, or applied for asylum in another European Union country prior to Finland, her /his case shall be reviewed there and she/he will be sent back to that country. Preserving family unity is an example of exception in this regulation (Council Regulation 343/2003, (6).

TABLE 2. Unaccompanied minor asylum seekers in Finland by nationality 2008-2010 (Finnish Migration Service 2011c)

	2010	2009	2008
Zimbabwe	1	1	
Unknown	2	2	1
Ukraine	1		
Turkey	4	6	3
Togo	2	2	
Somalia	117	201	353
Sierra Leone	2	2	
Serbia	6		
Russia	11	10	10
Ruanda	1		
Romania	2	1	
Others		4	6
North Korea	2		
No nationality	2		1
Nigeria	3	2	3
Niger		1	1
Morocco	1	1	2
Kosovo	2	3	3
Kazakhstan		1	1
Cameron	1	3	3
Ivory Coast	1	2	2
Israel	1		
Iraq	64	151	210
Iran	2	12	5
India		1	2
Guinea	1	6	4
Ghana	19	6	3
Gambia	2	3	1
Ethiopia		3	5
Denmark	1		
Democratic Republic of Congo	9	9	6
Congo	1	2	2
Burundi	1		1
Bulgaria	9	23	1
Belarus	4		
Angola	7	12	12
Algeria	4	2	2
Afghanistan	43	85	63
TOTAL	329	557	706

2.2 Reception center

Asylum seekers are mainly accommodated in reception centers, although it is also possible for a person to reside in a private home if s/he independently so can organize. There are three main types of reception centers. Group homes (ryhmäkoti) for unaccompanied minors typically under the age 16, supported housing services (tukisasunnot) for 16-to-17-year-olds and reception centers for adults or families with children.

Finnish legislation states that accommodation has to be organized so that family members can reside together and an applicant's special needs in terms of age, physical or psychological condition have to be taken into consideration (Laki maahanmuuttajien kotouttamisesta ja turvapaikanhakijoiden vastaanotosta §19). Accommodation in reception centers for children aged 0 to 15 is sized based on Finnish Child protection act. Accommodation for children aged 16 to 17 includes fewer, although similar services and resembles housing services. According to United Nations Convention on the Rights of the Child, adults and under aged should not be housed in the same department (Yksintulleet – näkökulmia ilman huoltajia maahan saapuneiden lasten asemasta Suomessa).

According to Quality manual for working with unaccompanied minor asylum seekers, for children under age of 16 food is prepared by reception staff, the ones living in supported housing facilities cook their own food and particularly in the beginning, help form reception center's workers is needed. Nutrition is part of care and up-bringing support aimed at unaccompanied minors. Unlike adults or families, each one has their personal worker. In this research, this kind of worker was referred to as personal counselor. Additional services for underage asylum seekers are hobbies supporting physical and psychological well-being. (Alaikäisten vastaanottotoiminnan laatukäsikirja, versio: 2.0).

Besides accommodation, all asylum seekers are entitled to income support, essential social and health care services and interpretation services; in addition, work or study activities may be organized. Further, costs of legal help are covered on behalf of the reception center to ensure a fair and effective process. National legislation focuses particularly on children's rights by considering a child's best interest; those with special needs should receive counseling, rehabilitation and mental health services (Laki maahanmuuttajien kotouttamisesta ja turvapaikanhakijoiden vastaanotosta §19).

Essential social services include initial information and interview conducted by a social worker, psychosocial support if necessary, income support and support in moving to municipality after an applicant has received a residence permit. For under-aged, the social worker appoints a legal guardian and steers cooperation with professional network in and

outside of the reception center. (Alaikäisten vastaanottotoiminnan laatukäsikirja, versio: 2.0).

Essential health care services are composed of health examination including laboratory and x-ray examinations, assessment of need of care and vaccinating, if seen necessary. Initial examination is conducted by reception center's nurse; those asylum seekers who reside in private homes receive health info prior to moving. (Alaikäisten vastaanototoiminnan laatukäsikirja, versio: 2.0)

2.3 Professionals in a reception center

Qualifications and necessary amount of staff working with children aged 0 to 15 in reception centers are coherent with Finnish Child protection act. In one unit can reside maximum of seven children and there must be minimum of seven workers, unless several units operate in the same building, there should be minimum of six workers. Not more than three units can, however be housed in the same building (Lastensuojelulaki, § 59).

In national legislation it is stated that qualifications for professionals working in social welfare sector are applied also for work within group homes, for other age groups no such citations exist (Laki maahanmuuttajien kotouttamisesta ja turvapaikanhakijoiden vastaanotosta). Minimum requirements or recommended professional backgrounds are neither described in manual of quality care for work with unaccompanied minors (Alaikäisten vastaanototoiminnan laatukäsikirja, versio: 2.0). For some professions working also in reception centers, such as nurse and social worker, there are well precisely defined qualifications in Finland. Thus, the counselor's background can vary a great deal depending on the consideration of the employer.

The focus of services for minors aged 16 to 17 receive is more on housing and fewer support in daily functions compared to group homes, amount of staff per child is smaller. Each child has a personal counselor; together with rest of the staff they are responsible for daily care and upbringing. (Yksintulleet – näkökulmia ilman huoltajia maahan saapuneiden lasten asemasta Suomessa). In a reception center for adults there is far less staff per client and thus far less time to focus on an individual's needs.

Many of the clients in reception centers have had traumatic experiences in their past life and have uncertainties concerning future. As a result, professionals need many educational competences, professional skills and experiences to work with them. Payne (1996) presents that the theoretical, social knowledge consists of understanding of the organizational- and

legal contexts of work, social scientific knowledge about the human beings and their interactions and social work practice methods.

Professional is an expert in one´s field. She or he has experience and theoretical knowledge from that particular profession. Ketola & Kokkonen (1993) have suggested components of knowledge needed in social sector. Accordingly, a worker should have education in psychological, pedagogical and social theoretical knowledge, and in healthcare sector the worker should have knowledge of theoretical, medical, psychological, monitoring, planning and evaluative aspects. With that knowledge the social or health care worker is able to understand the components of the human´s welfare and health, social processes and the function of the society and is able to provide services supporting clients in their welfare process. (Ketola & Kokkonen, 1993).

Usually there is a director in a reception center, or if it is a sub-unit of a bigger center located somewhere else, an assistant director or senior counselor. In addition, depending on the size of the unit, part or full-time nurse, social worker and several counselors are also part of the centers. Doctoral services are typically arranged by purchase contract from private sector. The centers that offer ready-made food may have separated kitchen staff; mostly asylum seekers prepare their own food. Maintenance workers are not necessary, as cleaning is part of residents' work activities.

3 HEALTH AND ASYLUM SEEKERS

Health is defined as," a state of complete physical, mental, social well-being and not merely the absence of disease or infirmity" (WHO 1946, cited in Downie, Tannahill & Tannahill 1996). Health is a positive state seen as well-being. Asylum seekers consist of diverse sub-groups with distinct cultures, languages, beliefs, values and historical developments.

Many refugees are at high risk for mental health problems because of their experiences such as war or trauma and displacement. Refugees' traumatic experiences, like imprisonment, physical tortures (beatings, electric shock, burning, asphyxiation, stretching, genital trauma and rape), psychological tortures (threats, isolation, mock execution, forced witnessing of torture or execution, sleep deprivation and rape), cruelty and violence in war, for example bombing and explosions, memories of destroyed homes left behind, hunger and life in refugees camps effect their well-being and daily life (Kemp & Rasbridge 2004).

Meadows, Thurston & Melton (2001) found out that the mental, spiritual and social factors are related in maintaining health of the immigrants. Health is influenced by stress, emotional trauma, experiences with abuse, family history, experience in refugee camps, leaving war torn countries where family members had been killed or hurt, the experience of immigration, and day–to-day survival or the availability or usage of medical resources are important. They stated that the physical and mental factors such as body ache, pain, sleeplessness and depression or crying are the symptoms of health risk. Feeling of sad, nervous, restless, and hopeless and worthlessness are symptoms of mental health states of the individuals (Dey & Lucas 2006).

According to Millar & Stephan (1993), adaptation and integration into a host society have an effect on immigrants' health and well-being. Choudry (1998) presents that as a result of migration, the stress of adaptation and acculturations, the feelings of powerlessness and changes of life style are risk factors for ones´ health. Pender (1987) proposes health promoting behaviors to maintain or improve one's' health.

Health improvement and health care services in Finland for asylum seekers are limited in comparison with national population. Policy makers recommended that services for pregnant women and for children should be nearly equal with permanent population of Finland (Laki maahanmuuttajien kotouttamisesta ja turvapaikanhakijoiden vastaanotosta, § 19). Even though the refugees are coming from different social settings such as war or natural disaster and they are suffering physically and mentally, the policy makers have drawn a limited medical access during the asylum procedures. In this study it is aimed to know how professional promote the health of unaccompanied minor asylum seekers in their daily work.

Health promotion behaviors maintain or improve one´s level of well-beings. Choudhry (1998) stated that health is a part of connectedness of the body, mind and spirit. A deep sense of faith helps the people who come through difficulties and stress. As a sense of religious and spiritual beliefs are also important for the immigrants to maintain their health (Choudry, 1998). She also mentioned that wellness programs for these immigrants include health values and traditional health beliefs. So being, Finnish professionals in reception centers should be aware of clients' cultures and their beliefs.

A study carried out with immigrant women's health promotion in Canada, (Choudhry 1998) concluded that sudden changes of life style behavior, migration and new culture, Isolation from the family and loneliness are risks for health promotion. Health needs of many clients, whose cultural background differs from that of majority population, are not well understood or information is inadequate because of the linguistic and culture limitations of health

surveys (Health and welfare, Canada 1993, Ontario, Ministry of Health 1991 cited in Choudry 1998).

3.1 Health promotion

Health promotion, according to O'Donnell (1989), is a form of science that aims to support people to change their behavior to reach optimal health. Optimal health is presented as an entity consisting of physical, social, spiritual and intellectual parts that should be in balance with each other. In order to reach this state of health, supportive environment has been suggested to be the most significant single factor. In addition, increasing an individual's awareness is necessary.

World Health Organization (WHO 2010) defines health promotion as "systematic series of actions directed to people to increase control over and improve their health". Similarly to O'Donnell's definition, WHO sees it as an intervention for improving health, for example by providing sufficient nutrition, a supportive environment, health education and an assessment to display achieved changes.

Raphael (2000) refers to a WHO document that presents social components of health. Social environment, stress, early life, social exclusion, unemployment, social support, addiction, food and transport are mentioned to influence one's health. Also economic inequality is seen to influence health. Green & Kreuter (in Bartholomew, Parcel, Kok & Cottlieb 2006) defined health promotion as "any combination of education, political, regulatory and organizational supports for actions and conditions of living conductive to the health of individuals, groups or communities".

Hyndman (1998) stated that a person's health can be promoted through community action, developing personal skills, building healthy public policy, creative- supportive environments and re- orienting the health services. Based on the evidence of health promotion, health promoters should know which are the factors influencing health, be able to choose right activities for health and then evaluate the effectives of activities they chose.

Health promotion studies offer an opportunity of health benefits for individuals or groups by improving understanding of harmful health outcomes, by reducing involvement in health risk behaviors, and in the prevention of both. Health promotion practice may include health education, behavioral interventions such as counseling, monitor or improve existing programs and policies to enhance health.

According to WHO's definition (WHO 2010), health promotion is a process of enabling people to increase control over and improve their health. Health promotion represents a comprehensive social and political process. In addition to supporting an individual's skills, it seeks to change social, environmental and economic conditions through reducing their impact on public and individual health.

In Bunton & Macdonald (2002) most definitions of health promotion (Tones 1983; WHO 1984; Tannahill 1985; Kickbush 1997; Bracht 1999; Griffiths and Hunter 1999) accept that both individual (lifestyle) and structural (fiscal or ecological) elements are playing critical parts in health promotion strategy. They also referred to Rootmen 1995; Raeburn and Rootman 1998 by presenting different definitions of health promotion as capable of representing different options or models from which a health promoter should choose according to his/her task and program, health promotion goals and the target population as well as the focus and the type of intervention. Pirskanen, Pietilä, Rytkönen & Varjoranta (2010) presented health promotion according to Ottawa Charter (1986) as a healthy social development, as achievement of a healthy environment, and improvements to both personal and communication skills, and as development in health services.

Beser, Bahar & Buyukkaya (2007) presents Pender's promotion model that consists of three components that are cognitive-perceptual or psychological elements that determine participation in health promoting behaviors; modifying circumstances that influences the cognitive-perceptions factors and influence the health promoting behaviors, and the likelihood of actions directed toward enhancing or maintain well-beings. The cognitive-perception factors include importance of health, self-efficacy, and health promotion behaviors. Healthy life-style behaviors are self-actualization, health responsibilities, exercise, nutrition, interpersonal support and stress management. Pender (1987) stated that health promotion indicates activities directed towards sustaining or increasing the level of well-being, self-actualization and personal fulfillment of a given individual or group.

Psychological theories suggest effective approaches for health promotion. According to Bennett & Murphy (1997 in Bunton & Macdonald 2002), physical and social environments and psycho-social aspects of health can be improved through psychological approaches. Taylor (1990 in Bunton & McDonalds 2002) suggested two approaches to promote the heath: Humanistic approach: client-centered approach which involves people in determining their health needs and developing the resources and skills, the radical humanistic approach focused on client- centered participatory learning within a social context of relationship. According to this model, health promotion can be reached through the development of social, organizational and economic networks.

Bartholomew, Parcel, Kok & Cottlieb (2006) expressed individuals to have a close relationship with biological, psychological and behavioral characteristics of their environment. These environments include physical, social and cultural aspects that exist across the individuals' life domains and social stings. Accordingly, the structure of the environment influences health promotion of an individual. Authors referred to Green (1997), who contributed to discussion by stating that social and physical environments influence in health promotion on general level and in individual's risk behavior. Accordingly, relationship between individuals and their environment influences health in two ways. First, mechanistically, through mechanisms in general system in which small changes in the social environment can lead to large changes in individual behavior. Secondly, various levels are viewed as embedded systems.

Asylum seekers are often coming from countries where their life is in danger facing a lot of problems and fear to live there. When they come to Finland and apply for asylum they start their life in reception centers. While they are in reception center, they need help and support from the professionals working there. In this study it is aimed to find out how the professionals promote asylum seekers health in their daily work, content and methods of health promotion and establish recommendations for good practice.

3.2 Health care system for asylum seekers

Pirinen (2008) has studied asylum seekers' health in Finland, he comments that there is not much said about services in basic health care. If no acute health care exists, an asylum seekers first encounter with health services will be with a reception center's nurse in form of health interview followed by laboratory and x-ray examinations. Sick ones, the disabled, children younger than 7 years, pregnant mothers and those whose x-ray or laboratory results are deviant will be referred to a doctor. Ministry of Social and Health Care has outlined health issues to be reviewed in initial health check-up and conditions for referral to doctor, see table 3, page 17 (Pakoalisten ja turvapaikanhakijoiden infektio-ongelmien ehkäisy 2009).

According to Mikkonen ja työryhmä (2002), health care practices concerning children and mothers have developed so that they receive same services with those residing permanently in Finland. The problem is that there are no specialized mental health care services and even the standard services are over-used.

TABLE 3. Asylum seekers' initial health care services (Pakolaisten ja turvapaikanhakijoiden infektio-ongelmien ehkäisy 2009).

Nurse's interview	Diseases Screened in Examinations	Referral to Doctor
•Areas of residence and circumstances before moving •Previous diseases and treatments, including tuberculoses, HIV, syphilis •Possible exposure to contagious diseases (tuberculoses in vicinity, risk factors for HIV) •Current medication •Vaccination history, scar of BCG •Current symptoms, in particular cough, bloody coughing, pain, loss of weight, fever, lack of appetite, diarrhea, nightly sweating •Length and weight	•Active tuberculoses •Hepatitis B •HIV •Syphilis •Children under 16 1. Need for BCG vacination 2. Presence of intestines infections	•Children under age of seven •Disabled •Pregnant mothers •Sick ones based on nurse's interview •Those, who had deviances in examination results

A recent report conducted by Ombudsman for Minority's office concerning actualization of unaccompanied minor asylum seekers' interest underlines the same problem. A lack of access to specialized social and health care services is denounced (Parsons 2009). Parsons claims that most of these children have had traumatizing experiences, many of them being thereafter symptomatic either psychologically or physically. However, there are no mental health care or therapy services in Finland specializing in treating children with post-traumatic disorders. These children only reach mental health care services when in acute need of care and expert long-term therapy services may not be found.

In a study focusing on adult Iranian asylum seekers' experiences of services received in reception center, the services were seen severely inadequate and there was more satisfaction with mainstream health care system in general. Long waiting times and lack of certain treatments resulting to inequality with Finns were main concerns. Fewer complaints regarding reception center staff were expressed, however, more awareness of different cultures and diseases not common in Finland were hoped for. Other factors seen to harm their health were poor hygiene level in reception centers and language barrier with service providers due to unqualified interpreters. Researcher suggested that more information on general health and legal rights of asylum seekers needs to be distributed. (Clarke ed, 2003).

3.3 Asylum seekers' health

Based on an interview research with minor asylum seekers, the most difficult and painful thing affecting their health, was to be separated from family and parents (Helander & Mikkonen 2002). Both children themselves and reception centre's staff reported minors to suffer from many psychosomatic symptoms and problems. Difficulties in concentration, insomnia, nightmares, eating disorders, bed-wetting, depression, aggressive behavior, head and stomach aches and stuttering were common. Staff also reported suicide attempts. (Helander & Mikkonen 2002). In their recommendations concerning health care services, the researchers proposed in particular to develop availability and forms of mental health services, which should be shortly after arriving to Finland. Children were in need of long-term help, activity based methods were seen suitable and promising, as for some minors building trust or realizing the benefits of discussion-based therapy is challenging (Helander & Mikkonen 2002).

Sourander (2007) notes the prevalence of traumatizing experiences in refugees' past as well as in the application phase. Despite stating that psychiatric research on unaccompanied children's mental health is scarce, Sourander does present mental health issues as their most common health problem in his article. He refers to his previous study (Sourander 1998) in which reception center's professionals described refugee children's symptoms taking forms of sadness, impulsivity, worrying, severe mood swings, loneliness, distrust and difficulties in concentration. Staff had estimated that more than half of children have clinically significant symptoms, thus Sourander (2007) concludes that children are in need of psychosocial support already in reception phase. Children in their part had experienced the staff as distant and a target of feelings of unfairness and anger.

Mental health issues arise also in research concerning adult asylum seekers' well-being. A representative study comparing Afghani, Iranian and Somali asylum seekers' with refugees' health in the Netherlands reported asylum seekers to have poorer health than the refugees of corresponding groups (Gerritsen, Bramsen, Devillé, van Willigen, Hovens, & van d. Ploeg 2006). Suggested reasons for differences were uncertainty about residing in the country, living conditions and acculturation but also differences in political atmospheres both in countries of origins and the Netherlands during the time of migration. Among asylum seekers, 59,1% estimated their general health status to be poor (42% for refugees), 48,4% stated having more than one chronic condition (46,5% for refugees). Further, 28,1% of asylum seekers reported having post-traumatic stress disorder symptoms (refugees 10,6%) and as many as 68,1% depression or anxiety symptoms (refugees 39,4%).

Length of asylum process was found to have a significant effect on quality of life, disability and physical health. Well-being of Iraqi asylum seekers who had resided in the Netherlands

for six months was compared with a group whose stay had been on average more than three years and the latter group was significantly worse off (Laban, Komproe, Gernaat, & de Jong 2008). Explanatory reasons in addition to long process were harmful life experiences and living conditions in terms of comprehending privacy, housing, financial situation and safety. Same group of researchers studied Iraqi asylum seekers use of medical services concluding that despite high rate of psychiatric disorders mental health service use was low (Laban & al. 2007). There was also a mismatch between the kind of health service used and health condition, non-mental health care was more attended. It was deduced that instead of mental problems asylum seekers present physical ones, the staff in reception centers and general practitioners did not recognize the conditions or referrals to specialists were not prescribed.

A non-generalizable self-reporting survey conducted among asylum seekers in England disclosed that more than half of the respondents felt the need to consult a doctor due to symptoms, less than a quarter had no symptoms, 68,5% expressed need of a dentist at the time (Blackwell, Holden, & Tregoning 2002). Nearly a third was taking at least one medicine, most commonly central nervous system agents such as analgesics or antidepressants; rate of gastro-intestinal disorders was also high. In comparison with original local population, asylum seekers' vaccination rates were low. Researchers stated poor health care system in country of origin, hardship in life, alien environment, and threat of physical abuse and poor housing conditions to be explanatory reasons for asylum seekers' state of health.

A study of Iranian asylum seekers experiences of Finnish health care system found that the participants were active in preventive health care by maintaining good hygiene, physical exercise and good nutrition (Clarke (ed.) 2003). Families had better nutrition than singles, who were mostly men as mothers were the ones preparing more regular and healthy food.

This study was interested in how professionals in receptions encountered situations described in previous research. The research questions looked on how do they promote health in their daily work, through which methods and what is the content of health promotion. Recommendations for good practices were established.

4 GOOD PRACTICE

A good practice is a way of working, a method which provides good results. The main characteristics of good practices help to identify the problem and evaluate it. Good practice has model that describes a holistic process. The process consists of different parts that are identification, evaluation, condensation, validation and dissemination. Best practices can be used for interventions and are often based on reviews that emphasize internal validity. (Kahan & Goodstadt, 1998, in Bartholomew & al. 2006).

Good practice model allows making conclusions from the evaluation related to functionality or effectiveness of the practice. This promotes other professionals to apply the good practice in their own work environment. And it also helps to develop one's method of working pattern and provides considerable information about the improvement of health and social welfare service practices. (Sosiaaliportti 2010a).

A broad definition of practices is a network that consists of for instance social workers, nurses, doctors, and family members, care givers, their activities and interactions, and any kind of resources (for example theories, tools, models, technical art facts, norms, goals, rules, or money) that can be applied by professionals in their own working environment. Practices may be effective and function in a larger context and it is impossible to limit clearly a practice from its context. For this reason, the evaluation of a practice should contain knowledge of the resources needed when implementing a practice and the change that the practice aims for. (Sosiaaliportti 2010a).

The National Institute for Health and Welfare in Finland (THL) supports and promotes the identification, evaluation, description and implementation of good practices in the field of health care and social welfare sector. THL has also developed a model for describing a good practice. It offers a tool for a concise description of practices that have been evaluated. The "goodnesses" of practices are evaluated in terms of their functionality and effectiveness. The model provides no ready-made evaluation methods or criteria, but these are defined in the evaluation process of the practice that is being described.

The main characteristics for good practices are as follows (Sosiaaliportti 2010b):

1. Functional and/or effective in its specific context and evaluated to achieve good outcomes for the user
2. Ethically acceptable
3. Based on versatile knowledge on the effectiveness of the practice

4. Described in such a manner that the reader is able to assess what kind of knowledge its practical effectiveness is derived from and whether this knowledge is incomplete in some respects
5. Described concisely

The good practice process (see Figure 1) consists of identifying, evaluating, condensing good practice, analyzing it critically and validating it through dialogue and promoting its implementation. The hybrid nature of the good practice process permits to start the process to describe the good practice even before assessment.

This model can be used for describing practices that have been evaluated and found good in the context of basic activities or in a development project that are consistent with the characteristics of a good practice defined by THL. The model is also applicable to improving or developing the existing services. In this study, the main characteristics and model for good practices will be utilized in presenting findings and discussing them.

FIGURE 1. The good practice process
(Sosiaaliportti 2010c)

Regarding asylum seekers health, statement for good practice for separated children in Europe has been set in a collaboration of United Nations Commission on Human Rights (UNCHR), United Nations Children's Emergency Fund (UNICEF) and Save the Children in 2009. The statement seeks to offer a simple overview of principles, practices and polices necessary for achieving children's rights. Health services are described only briefly on the surface by requiring access to preventative, remedial and emergency health care services equally with national children. Physical and mental health needs, such as trauma or ill health deriving from past experiences as well as racism are required to be paid special attention to. According to the statement, counseling or therapy is seen crucial for some separated children's recovery. (Statement of Good Practice 2009).

5 PURPOSE AND RESEARCH QUESTION OF THE STUDY

The purpose of this study is, to find out how the professionals promote asylum seekers' health in a reception center and to establish recommendations for good practice in cooperation with the professionals by utilizing action research model.

Research questions:

1. How do professionals promote unaccompanied minor asylum seekers' health in a reception center in their daily work?
2. What is the content of health promotion done by reception center professionals?
3. What are the methods used to promote unaccompanied minor asylum seekers' health by reception center professionals?
4. What are the good practices for promoting unaccompanied minor asylum seekers' health in a reception center?

Professionals in a reception center were interviewed and initial recommendations for good practices established through data analysis. In findings chapter, it is presented how professionals promote health in their daily work, what is the content and methods of health promotion used. Based on these findings, initial recommendations were established by researchers. Initial recommendations were then commented on by participants establish final recommendations. Then recommendations were discussed in the light of literature review.

This study limits in establishing recommendations. To implement recommendations, re-evaluate and share the knowledge with policy makers will be tasks of a new action research

cycle. Policy makers play an important role in offering good health promotion practices for asylum seekers in the future in Finland.

6 RESEARCH METHOD

The overall research design followed the cycles of action research and qualitative approach was used. The aim of qualitative research is to find out the meaning and understanding rather than verify the truth or predict outcomes. The goal is to research with people rather than on people (Talbot, 1995). According to Leininger (1985), qualitative research methods help in gaining deeper knowledge of human realities and focus on identifying, documenting the values, meanings, world views, and believes of life events, situations, or other phenomenon. He described it as “often the initial way to discover phenomenon and to document unknown features of some aspect of people, events or the life setting of people under study”.

The research questions of this study were to find out how the professionals’ promote asylum seekers’ health in a reception centre in their daily work, what were the content and methods of health promotion. Qualitative research method was used to gain in-depth, descriptive information. To answer the fourth research question, establish recommendations for good practices, action research design was applied through participants’ collaborative feedback in the light of literature review.

6.1 Action research

Cohen and Manion (cited in Bell 2006) stated that action research is appropriate when specific knowledge for a specific problem or a new approach is to be established for an existing system. Action research approach is carried out by practitioners who have themselves identified a need for change or improvement. The aim is to ‘arrive at recommendations for good practice that will resolve a problem or enhance the performance of institution and individuals through changes to the rules and procedures within which they operate’ (Denscombe 2007). In this research, professionals of a reception center were involved in establishing recommendations for good practices concerning unaccompanied minor asylum seekers’ health promotion through sharing their expertise and knowledge from perspective of daily work.

Denscombe (2007) also claims that in action research, the researcher collects data, which provides evidence to support claims for action. This is a starting point, but when the

investigation is finished, the findings will have been considered by all participants. Participants continue to review, evaluate and improve practice. Research involves a feedback loop in which initial findings generate possibilities for change, which are then implemented and evaluated for further investigation (Denscombe 2007). In this research, feedback loop was referred to as collaborative feedback and it was conducted based on initial recommendations that were derived from data analyses of participants' interviews.

Unlike in traditional qualitative research, the goal of action research is not to discover new facts but to bring about a practical solution to defined problems (Stringer 2004 in Carson, 2007). The goal in this research was to establish recommendations for good practices as asylum seekers have limited access to health care and focus on health promotion can be a way of bringing about the change.

The role of participants, or stakeholders, in action research is one of the key characteristics distinguishing it from more traditional approaches and the extent of it is discussed in depth in literature. Action research is seen as a method that has an interest in combining knowledge and action and emphasizes the stakeholders' role enabling them to take part in decision making and addressing practical problems to improve a certain situation (Street 2002 in Robinson, A. & Street, A., 2004). Champion would include participants "-- in each and every stage of the inquiry.", thus starting from research design, planning, taking action and reflecting (2007).

Also Winter & Munn-Giddings (2001) see the purpose of action research to change the circumstances, not only to describe current situation. They contribute to the role of participants by highlighting the importance of having a group of people committed to research relevant to their purposes in order to make a change. Walsh, Grant & Coleman (2008) propose that action research is "a cooperative process of inquiry", where ownership, focus on issues of interest, reflection and re-negotiating aims, membership and methods ideally belong to the group. However, they stress cooperation with participants submitting final ownership to the researchers. Idea for this study was identified by researchers and participants had an important role in two steps, in data collection and in implementation in form of collaborative feedback. Participants were firstly interviewed and secondly they commented initial recommendations for good practices.

In order to achieve change that action research aims for, it is formulated of a chain of six steps and can be presented in form of a cycle. Carson (2007) suggested that task of the first step is to identify a research subject and design, reviewing literature and familiarizing with action research theory. Secondly, participants ought to be involved and data collected. Thirdly, data has to be analyzed followed by the fourth step of sharing the results with

participants. The fifth step comprises taking action for change. After the first complete cycle, as action research aims for continuous improvement, another cycle can be carried out starting with reviewing of priorities.

Action research design was applied for the needs of this study and consisted of six steps. In the first step of this study (see figure 2), the researchers identified the research problem, design and conducted literature review for the purpose of this study. This step was referred to as assessment phase. In the second step of study, participants were invited, data collected through thematic interviews and analyzed. Thirdly, based on analyses, a proposal for recommendations was formulated by the researchers and collaborative feedback collected from participants for further developing the recommendations. In the fourth step, feedback was taken into account and, in combination with data search in step five, final recommendations for good practices were established. Results of this study were shared with the reception center and people interested in this study.

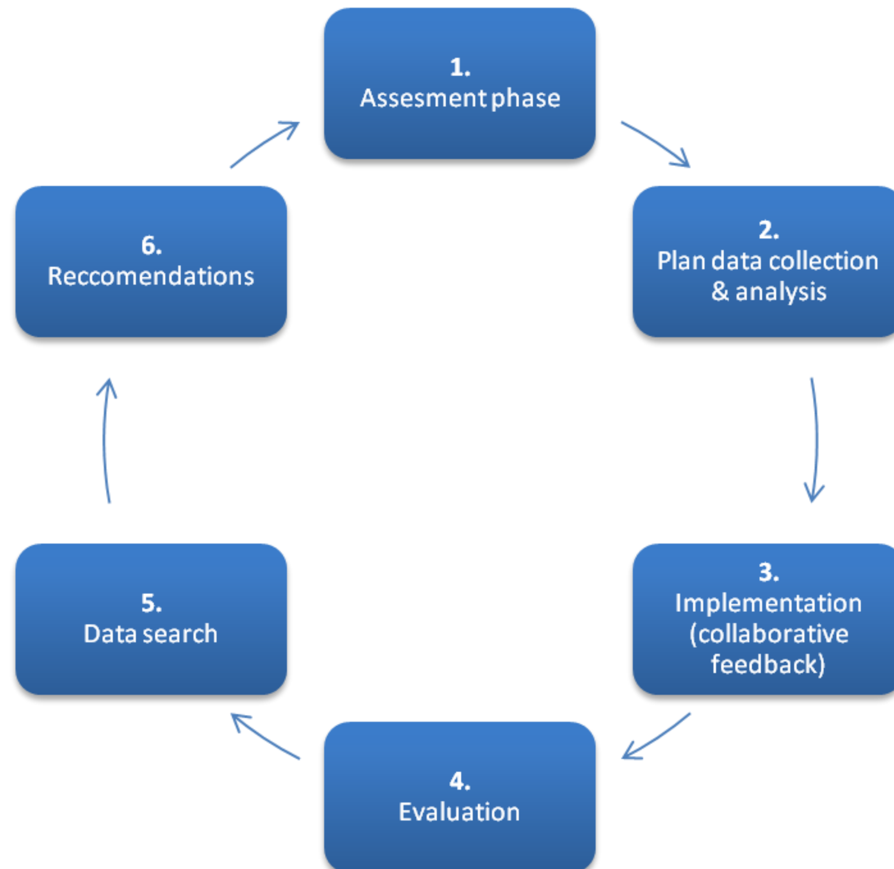

FIGURE 2. Steps of action research process

This study was limited in establishing the recommendations for good practices. To implement and evaluate these recommendations in the future will be up to a new cycle of action

research. Given the limited time in hand it will not be possible to implement or further study the effects of recommendations in practice.

6.2 Participants in this study

In traditional qualitative research, participant is defined as a term used to refer to those individuals who provide information to researchers about a topic under study. Traditional research with people involves two groups: those conducting the research and those who provide information. In a qualitative study, the individuals of the groups cooperating in the study have an active role in the research, and are usually referred to as study participants, informants, or key informants. (Polite & Beck 2004). Winter & Munn-Giddings (2001) refer to informants in action research as participants or stakeholders. In this study, term participants were used and they had a significant role in steps two and three, data collection and collaborative feedback.

According to Morse (1989), the researcher may choose to interview informants with a broad, general knowledge of the topic or those who have undergone the experience which is considered typical. The groups of participants cooperating in this study were professionals working in a reception center.

As generalizations are not pursued in qualitative research, four voluntary participants were involved. However, opportunity to participate was offered to other staff members too. Participants were informed beforehand and a short description of the study was given to them.

Participants were invited in two ways. Firstly, as health promotion was presented to be composed of social, health and environmental factors (see chapter 3.2), social worker, nurse and senior counselor were purposefully asked to participate as they were in charge of those three factors within the unit. Further, counselors were asked to participate by an open invitation.

Four professionals took part in this study. Two men and two women, in age range of approximately 30 to 60. They all worked in the same reception center and had a different educational background and task: nurse, social worker, senior counselor and a counselor. Two of the participants had a refugee background themselves and three of them had educational background and previous working experience in social welfare and health care sector.

6.3 Method of data collection

Qualitative methods of data collection are generally more subjective in nature, as they seek the subjects´ view of the phenomenon on interest or description of experiences. Usually it provides a deeper and broader understanding of the phenomenon of interest than in quantitative research (Talbot 1995). Polit & Beck (2006) claim that insights from qualitative studies can guide practices, and guide in the important process of theory development for building knowledge.

In this study, the data was collected through a thematic interview method (see Appendix 1.1). Nieswiadomy (1998) defines an interview as a method of collecting information in form of face-to-face encounters that is used to collect factual data about people. Further, it can be used to measure participants' opinions, attitudes, and beliefs about certain topics.

Thematic interview is a method that focuses on themes common for all participants. Hirsjärvi & Hurme (2009) described the benefits of this type of interview by stating that "As the interviews will proceed through themes instead of detailed questions, it will allow bringing out the participants experiences rather than researchers presumptions".

As stated before, in action research, the focus lays in aiming for change rather than just describing the situation. Therefore, to establish recommendations, the participants were encouraged to present their desirable change in practice rather than only share their experiences or status quo.

There were four individual face-to-face interviews that were tape-recorded; this allowed the possibility to concentrate on what was being said and to listen again. The permanent recording captured the whole conversation, as well as the tone of the voice, emphases and pauses. Interviews lasted from 35 minutes to an hour and 15 minutes and took place from August to September 2010. One was conducted in the reception center and three in a community center. All interviews were conducted in Finnish language.

In the third step of research, collaborative feedback was collected from participants. Initial recommendations were handed over in written form in English. Participants wrote their comments and it was followed by a discussion with researcher in Finnish. Three out of four participants took part in collaborative feedback step.

6.4 Data analysis

Qualitative inductive content analysis was applied in this research. Graneheim & Lundman's (2004) model of data analysis was used. Analysis of qualitative data is an active and interactive process. Morse and Field (1995 in Polit & Beck 2006) noted that qualitative analysis is a process of fitting data together, of making the invisible obvious, and of linking and attributing consequences prior to the outcomes.

According to Burns & Grove (2003), data analysis is a dynamic interaction between the researcher and his or her experience of the data. The researcher needs to become familiar with the data. This involves reading and rereading the transcribed materials. Miles & Huberman (1994) state that qualitative data analysis focuses on reducing the large volume of data acquired to facilitate examination. This involves selecting, focusing, simplifying, abstracting and transforming the data (Burns & Grove 2003).

Tuomi & Sarajärvi (2002) explain that ideally, prior knowledge of research related theory or researchers' presumptions should not be involved in analysis process. They continue by stating that existence of strictly inductive analysis is highly questionable, as researchers do have theoretical knowledge of their field. Also in this study, the researchers had work experience in reception center and as care professionals, as well as theoretical ideas of health promotion.

Inductive analysis method was used, as the purpose was to derive suggestions for good practices from the participants rather than from literature reviewed previously in this study. No previous theory or research on health promotion in reception centre's professional's daily work context has been available for this study. Daily work as an object for interest can contain a variety of tasks that are not necessarily suggested as methods of health promotion by existing theory. Therefore, to be able to forward all the items mentioned by professionals, inductive analysis was chosen.

Data analysis began with transcribing recorded tape interviews into written texts from word to word. Pauses or tones of the voice were not taken into account. Analysis was done manually. Transcribed material was read several times to capture the meaning of the text. In this research eight steps of Granheim & Lundman (2004) method were used to analyze the data.

Graneheim & Lundman (2004) have proposed two main levels of using content analysis in relation to depth of data, manifest and latent content. Accordingly, manifest content is composed of visible and obvious components answering to question "what". On the contrast,

latent content analyses also the concealed or underlying meanings of data and seeks to answer to question "how". Analysis method used in this study followed Graneheim & Lundman's model. Manifest content was analyzed and interpretation of what was said in the interviews was kept to minimum in the early steps of analysis. Qualitative content analysis process contained the following concepts: manifest content, unit of analysis, meaning unit, condensing, abstracting, content area, codes, and categories (See figure 3).

FIGURE 3. Qualitative content analysis process (Graneheim & Lundman 2004).

In this study *manifest content* analysis was considered appropriate because it deals with the content aspects and describes the visible component of the text. Concept *unit of analysis* refers to an object of study, which was a whole interview in this case. It consisted of a whole and small enough entity to understand the context of the meaning unit.

Concept *meaning unit* is words or statements of participants' that relate to each other through their content and context. In this analysis we considered meaning units as words or statements that related to the same meaning.

The concept of *condensing* refers to the process of shortening the text while preserving its core meaning. Shortening the text is also referred to as reduction or distillation (Findahl & Höijer 1981 in Graneheim & Lundman). It refers to decreasing the size but not changing the quality of data that remains. In this research, condensation is used as a term for process of shortening text while preserving the meaning.

Abstracting, also referred to as aggregation, is a process of grouping condensed meaning units together under a higher logical level. In this analysis, shortened text was processed to create *content areas*. Patton (1990) referred to content area as a domain or rough structure, Barrosso (1997) called it a cluster (cited in Graneheim & Lundman 2004). In this analysis content areas were processed to create codes.

Codes are labels of meaning units. "Codes are tools to think with" while labeling condensed meaning units. Codes allow the data to be thought in a new different way and it can be understood in relation to the context of the text. Codes can be seen as objects, events or other phenomena. In this analysis codes were used to proceed into creating sub-categories and final categories.

*Categorie*s is a group of content which shares a commonality (Krippendorff 1980 cited in Graneheim & Lundman 2004). Category often includes a number of sub-categories. Sub-categories can be sorted and abstracted into a category and category can be divided into sub-categories. Categories are internally homogeneous and externally heterogeneous. All in all five categories were formulated on the basis of analysis. An example of analysis process is shown in Figure 4 (p. 31), where it presents how category named "emotional support" was created starting from coding level.

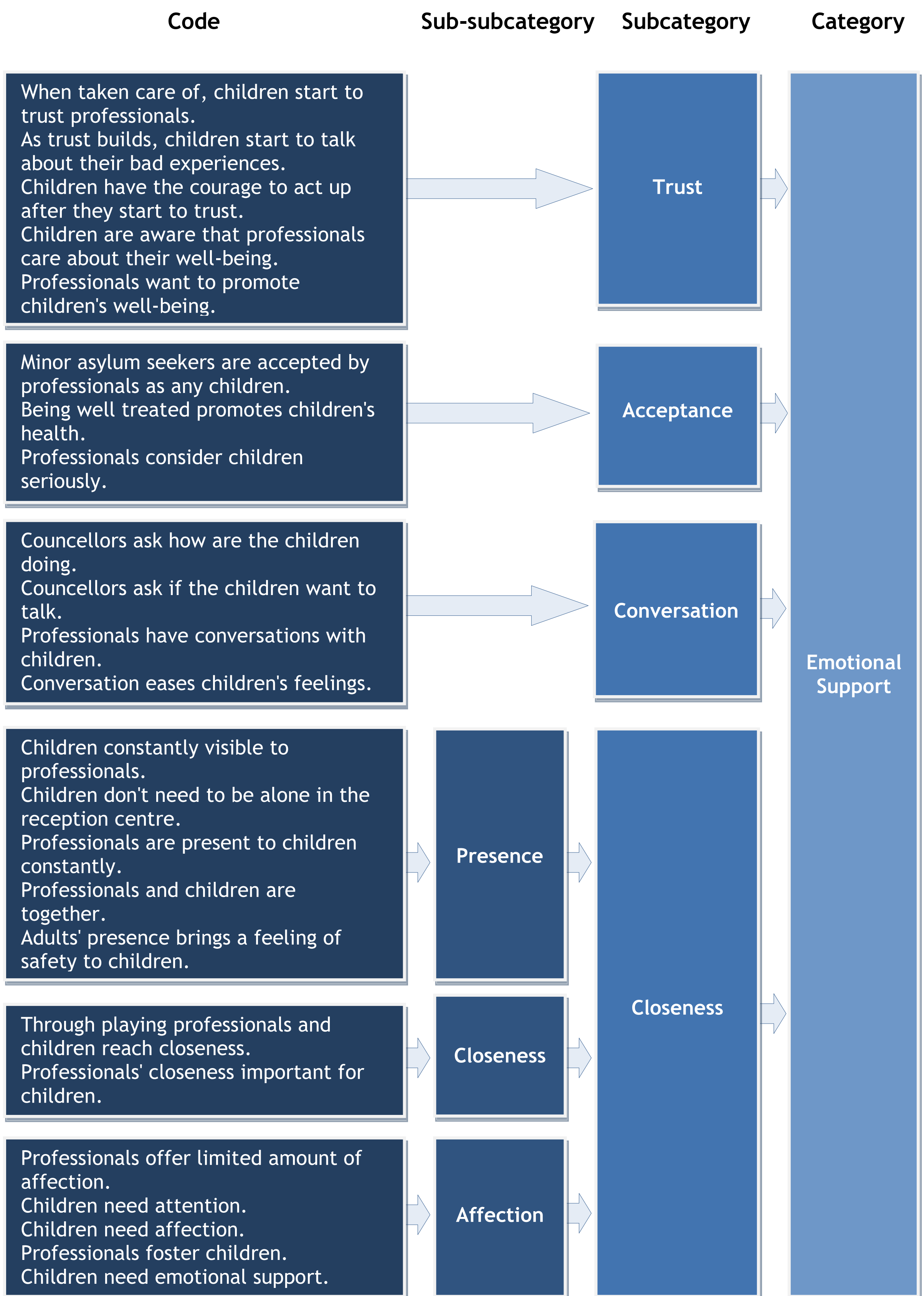

FIGURE 4. Data analysis process

7 FINDINGS

In this chapter, the findings are presented to answer the four research questions. The findings depict how the participants reported to promote unaccompanied minor asylum seekers' health in their daily work. Secondly, what was the content of health promotion in a reception center, thirdly, which methods were used to promote unaccompanied minor asylum seekers health. Lastly, based on the findings, initial recommendations for good practices within health promotion done in reception center are presented. Chapters 7.1 to 7.5 each present a main category of findings. In chapter 7.6 final recommendations for good practices are presented.

To illuminate the work done in daily context and give participants a more vivid voice, quotations from interviews were presented among findings. In addition, to illuminate the relationship between different sub-categories, findings are presented in form of Figure 5, each circle depicting a main category of findings.

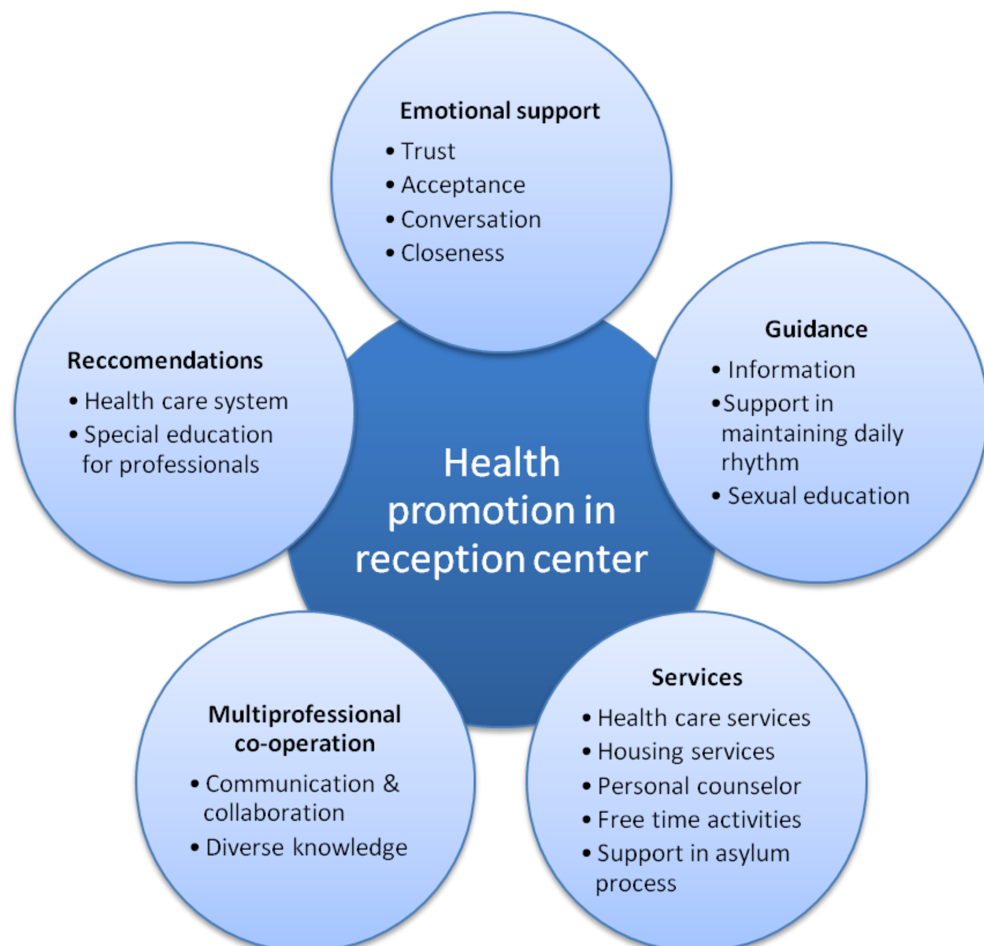

FIGURE 5. Findings of the research

7.1 Emotional support for minor unaccompanied asylum seekers

In daily work with minors, reception center professionals mentioned several aspects of emotional support. As minors were far away from their home and families, emotional support was seen one of the most important aspects of care. Children were said to be lonely and worried about their family's destiny.

Uncertainty about the future decreased minors' well-being and professionals' support was needed. Long waiting time for decision was said to increase mental health problems and need for emotional support, especially those who were waiting for deportation were strained. Feelings of trust and acceptance had an important role in working with children. Different types of conversation and closeness with professionals helped them to relieve their feelings.

Financial resources were seen scarce and therefore an inhibiting factor for good care. Professionals reported to be busy with taking care of other every day work rather than being with children. It was said that children would like to have more individual time with professionals and like to approach them when they sit still.

> " Nuoret on välillä kysellykki, eiks ohjaajil oo enää aikaa. Aika nopeesti me aikuiset mennään siihen, et luullaan, et kaikki muu on tärkeämpää kuin nuorten tai lasten kanssa leikkiminen, vaikka siitä ne kuitenkin tykkää."
>
> " Youngsters have asked at times don't the counselors have time anymore. Rather quickly we adults start to think that everything else is more important than playing with youngsters or children, although that is what they like."

More time was wished to be spent in particular with minors who have a special need for emotional support. Professionals had seen a need for individual care but lacked the time for that. It was wished, for instance, to take walks with children, have activities for small groups or make excursions with children in mixed groups.

7.1.1 Trust

Building trust with minors was seen very important to offer good care. In the beginning minors were afraid and not open about their past experiences or current feelings. Reception center was an unfamiliar environment to which they adapted bit by bit. Some remained distrustful throughout their stay and it was difficult to help children who did not talk about their

worries. Both reception center professionals and others in a child's network of care, for example general practitioners, were reported to be distrusted or even refused to attend.

Trust was established when minors were taken care of by professionals and they were aware that adults cared about their well-being and wanted to promote it. After trust was built, minors had the courage to show their feelings, share experiences and act-up if not well.

> " – hirveen ihana huomata, ku nuoret kiukuttelee ja on hankalia, nii huomata, et ne oikeesti luottaa meihin. Et ne uskaltaa niinku vänkätä ja kiukutella ja siitähän sen huomaa, et heil on turvallinen olo, et ei tarvii pelätä et täst tulee hankaluuksii."

> "- - it's terribly wonderful to notice when youngsters act up and are difficult, to notice, that they actually trust us. That they have the courage to sort of crank and that's how you notice that they have a safe feeling, that they don't need to be afraid of getting in trouble because of it."

> " – keskustelussa syntyy yleensä luottamus ja hän tietää, me ollaan huolissaan heidän puolesta ja se luottamus aiheuttaa siihen pikkuhiljaa kertomaan mikä on paisunut sisällä."

> "—usually during a conversation trust is built and s/he knows that we are worried about them and that trust causes to tell bit by bit what has swollen inside."

7.1.2 Acceptance

In addition to trust, feeling of being accepted was said to promote minors' health and well-being. It was vital for children to know that despite being asylum seekers and away from home they are like any other children and that they are considered seriously by professionals. Empathy and trying to understand a child were feelings that were tried to forward to children so that they would sense to be accepted.

“ – niinku normaali hänen ikäisten lasten elämässä, normaalikodeissa, ja se on se mikä edistää, on kokenut, että hänet hyväksytään, aikuisia, jotka näkee, että hän on normaalilapsi kuin mikä tahansa—“

“ – as in normal life of children in his/ her age, in normal homes, and that is what promotes, has experienced that s/he is accepted, adults that see that s/he is a normal child as anything—“

7.1.3 Conversation

Emotional support was given to minors through different types of conversations. Professionals asked how minors were doing in daily context. Further, they inquired if children were in need of talking about their feelings, this was a deeper contact. In addition, they had conversations with children according to their needs and specific topics. Conversation was said to ease minors’ feelings. However, it was difficult for minors to share their bad past experiences.

” – käyn juttelemassa tyttöjen kanssa. Ihan kyselemässä mitä kuuluu, miten voit ja onko jotain, mitä haluiaisit kertoo. Mun mielestä se jututtaminen on se kaikista tärkein.”

” – I go to chat with girls. Just asking how are you, how are you feeling, is there something you would like to tell. In my opinion this talking is the most important.”

“ Hän sanoi, silloin kun ahdistaa, hän tuu mun kanssa keskustelemaan ja se helpottaa, eli tää keskustelu, läheisyys, se on heille tarpeen—“

” S/he said that when feeling anxious, s/he comes to talk with me and it eases, so that this conversation, closeness, it’s necessary for them –”

Communication between professionals and minors was complicated due to lack of common language. It limited information shared and hindered quality of care. In particular, deeper communication in care was difficult as there was no common language. In using interpreters in a daily context, a professional had to assess when an issue was significant enough to order one as it was costly.

> “ – monille nuorille mä haluan lähestyä, tutustua enemmän, keskustella enemmän, mutta käytännössä on mahdotonta, kun ne ei osaa kieltä. Jos ei osaa kieltä, kommunikointi on hankalaa, varsinkin, jos haluat puhua niistä kipeistä asioista, se ei onnistu.”

> ” – I want to approach many youngsters, get to know better, discuss more but in practice it’s impossible as they don’t know the language. If you don’t know the language, communication is difficult, especially if you want to talk about those painful issues, it doesn’t work out.”

> ” - tulkilla on äärimmäisen tärkeä rooli, kuinka ymmärtää asiat kun ei oo omaa kietlä. Ja oon huommannut, osa tulkeista ei ymmärrä mitä puhutaan, mikä on esimerkiksi masennus. — Mielenterveyshoidossa tää on suuri haaste. Aikaisemmin oli eri alan erikoistulkkeja, hinnoiteltu erikseen. Tällä hetkellä ei ole, sitten hankaloittaa hoitoa.”

> ” – interpreter has an extremely important role, how s/he understands things, as it’s not hers/his own language. And I’ve noticed that some of the interpreters don’t understand what we talk about, what is for example depression. In mental health care this is a big challenge. Before there were specialized interpreters of different fields, separately priced. At the moment there isn’t, then complicates care.”

7.1.4 Closeness between professionals and minors

Professionals were working in three shifts and were present in the reception center around the clock, thus minors didn’t have to be alone. Adults’ presence and having cared available was said to give children a feeling of safety. Professionals kept the minors constantly in their sight and were together with them.

> “ – lapset on hirveen hyvässä huomassa sillen kuin meit on 4-5 ohjaajaa per vuoro, --, aina on aikuinen saatavilla. Täs on isot yhteiset tilat, ruokala ja olohuone, sitten toi meiän aula missä nuoret paljon on. Ne on koko ajan näkyvillä ja mun mielestä meillä ollaan tosi hyvin läsnä.”

> ”- - children get terribly well attention as there are 4 to 5 counselors per shift, -- an adult is always available. There are big common premises, eatery and

> living room, and then our lobby where youngsters are a lot. They are constantly visible and in my opinion in our house we are really well present.”

Professionals being present and available lead to closeness, which was important for minors’ well-being. Being close increased mutual trust. Adults and children playing together was presented as a natural way to reach closeness. Professionals reported about minors’ need for emotional support which appeared in their call for attention and affection. Professionals could offer a limited amount of affection in their adult role by fostering the minors and as presented above, being available and present.

> “—niille nuorille on läheisyys tärkeä. Kuin ne ovat yksin, niillä ei ole omaisia eikä tunne ketään. Se on ensimmäinen asia, hän ei tunne olevansa yksin—, ja turva on toinen tärkeä asia.”

> ”—for those youngsters, closeness is important. As they are alone, they don’t have relatives and they don’t know anybody. It’s the first thing, s/he is not feeling s/he is alone --, and safety is another important thing.”

7.2 Guidance for minor unaccompanied asylum seekers

Purpose of guidance was said to be to prevent minors from harm and also to ensure majority population’s safety through informing minors about Finnish legislation. Professionals reported to guide minors along daily routines. For instance, health education was given individually when workers and children encountered in every day chores such as cooking.

In addition to guidance in daily chores, professionals had recognized a need for sexual education. As most minors were teenagers, they were interested to know about that topic. Professionals had noticed minors trying to meet partners outside reception center. However, some of them had never heard about sex or felt ashamed or amazed. Some had had sexual experiences in their lives.

Professionals saw daily rhythm as a basis for daily living and presented supporting minors to stick to it as one of the key daily functions. Rhythm structured minors’ lives and promoted also health of those children who were not well.

7.2.1 Information for minor asylum seekers

Firstly, minors were informed about nutrition and about what does a healthy meal consist of. Secondly, over-16-years-olds were taught how to cook and how to store food in a proper way. Storing the food inappropriately was seen as a health risk. In addition to counselors, nurse was following what kind of meals youngsters ate and informing them about healthy food. Children's meetings were a forum for giving guidance in group, as all the children residing in reception center took part of those meetings.

> " Oli hyvä, kun meillä talokokouksessa kun nyt on ramadan aika ja usealle tulee vatsaongelmia kun ne päivisin ei syö ja öisin syö raskaasti, niin keittiöhenkilö kerto, miten aloittaa se ruokailu, mikä on parempi vatsalle."

> " It was good, when in our children's meeting as it's Ramadan time now and several one's get stomach problem when they don't eat daytime and in the nights eat heavily, so the kitchen staff told how to start that eating, what is better for the stomach."

Further, professionals taught minors how to use their monthly income support so that it would suffice. Professionals guided children to meet the nurse if they were not well and gave information about health and healthy way of living by themselves. Hygiene was a topic of general guidance. More group information was said to be needed for minors.

> " Ihan lyhyesti perushygieniasta puhuttu, että suihkuttamisesta lähtien, vaatteiden pesusta, kaikista niist, mitä ihmisarkielämässä tarvii huolehtia."

> "It has been told about hygiene just briefly, like starting from showering, washing clothes, and all those things that one needs to take care in human daily life."

7.2.2 Support in maintaining minor unaccompanied asylum seekers' daily rhythm

Maintaining daily rhythm and routines were seen as factors promoting minor asylum seekers' health. Professionals were in charge of organizing reception center's everyday activities and supporting minors in maintaining their own daily routines. Daily rhythm consisted of four elements that were regular mealtimes, sleeping rhythm, going to school and participating in hobbies.

> “-- aamulla herää, käy kouluun, sitten syömään, iltapäivällä on harrastuksia, illalla on taas ruokailu. Ja rytmi on lähinnä se joka tuo normaalielämästä kiinnipitämistä ja sitä kautta edistää terveellistä tapaa elää.”
>
> ”—in the morning s/he wakes up, goes to school, then to eat, in the afternoon there are hobbies, in the evening there is eating again. And rhythm is mainly what brings holding on to normal life and through that promotes a healthy way to live.”

In addition to support minors in sticking to normal life and promoting health, importance of daily rhythm was emphasized also for those youngsters who were not well. Minors suffered from sleeping difficulties, they were far away from family and bad past experiences came to their mind in the night time, and thereby professionals help to follow daily rhythm was needed.

> “ – on hyvä, että aina pidettäis kiinni nukkumaanmenoajasta --- et lapset menee sovittuna aikana nukkumaan. Samoin se herätyskin, et on säännöllinen aina. Arkirytmi on tosi tärkee mikä varmasti edistää sitä hyvinvointii, aamulla herätään ja mennään kouluun, ei vaan jäädä sinne sängyn pohjalle makaamaan.”
>
> ” – it would be good that we would always stick to sleeping times -- that children go to sleep in agreed time. Also waking up, that it is always regular. Daily rhythm is really important which for sure promotes well-being, in the morning one wakes up and goes to school, not just lay in the bed.”

7.2.3 Sexual education for minor asylum seekers

Sexual education was given by the same professionals who were working in reception center and were familiar to minors. After the need for sexual education had been recognized, the staff was trained first, as not all professionals were aware of sexuality related issues or how to deal with minors’ sexuality-related issues.

Based on training, counselors held group activities and discussed individually with minors. Knowledge about human anatomy, sexuality and contraception was given. The Professionals’ wish was to give suitable information by themselves as adults, as they had noticed that

minors were trying to explore independently on internet and to meet partners. Trust and being close, familiar adult helped professionals in approaching minors with this delicate subject.

> “ Jos huomaa, nuori surffaa netistä sellaista sivustoa, joka ei oo sopiva heidän ikäisille, sitten ohjaaja voi puuttua ja ihan kuinka on solminut suhteen nuoren kanssa.”
>
> “If you notice that a youngster is surfing that kind of pages in internet that are not suitable for his/hers age, and then a counselor could intervene according to what kind of relationship has been established with the youngster.”

7.3 Services for minor unaccompanied asylum seekers

Based on participants’ comments, non-health care services were divided into three categories. Firstly, into those that helped minors to cope in daily living. Secondly, every minor was appointed a personal counselor, whose role and relation to a child was seen significant in comparison to other professionals. Lastly, minors received support and services concerning their asylum process.

Services and good practices arising from interviews are presented below. Some minors were said to criticize care and services available for them and appreciated received care only after moving away from reception center.

7.3.1 Health care services for minor unaccompanied asylum seekers

As asylum seekers were registered inhabitants in Finland and are not part of permanent population, they had limited access to health care and welfare services and therefore no right to use public services as such. According to the Finnish act they are entitled for acute and necessary care. Contradictorily, professionals reported preventive care, which is typically not part of asylum seekers care programmed, to be more cost effective and easier, than providing care when a client was already seriously ill.

Minors, however, have a wider right to receive care than adult asylum seekers (Finnish Integration Act). Care offered was criticized by minors and some even refused to meet nurse or general practitioner due to lack of trust or not understanding their own state of health. In

this chapter, it is described what kind of health care services were available and which aspects were seen functioning well within this limitation of care.

There was a nurse working in reception center from Monday to Friday. Typically a client's first encounter with the nurse was health related interview when arriving to Finland. This interview was conducted with all the asylum seekers and nurse interviewed also those who had moved from another reception center. The interview lasted for an hour and interpretation services were used. Current health, health history, traumatizing experiences, nutrition and basic information about sexual education were covered in the interview. Nurse offered time also for minors to ask questions themselves.

According to participants of this research, nurse was said to be well present in daily functions and had an active role. The nurse observed minors' well-being through participating in daily reports, by following what the children were doing and by communicating with other professionals. If needed, nurse gave information to minors for example about healthy food or hygiene.

> " On aktiivinen sairaanhoitaja, joka on liikkeellä, kaiken aikaa katsoo ympärilleen miten lapset käyttäytyvät, miten lapset on."
>
> "There is an active nurse, who is on the move, looking around all the time how are the children behaving, how are the children."

Within the reception center, nurse gave consultation to other professionals in form of conversation-based support. Personal counselors had discussions with nurse considering children named for them. Further, minors sought advice from nurse also by themselves in health related issues.

> " Käytiin just yks päivä pitkä keskustelu näistä mun tytöistä, et mitä heiän kanssa vois ytehdä. Mitä terveydenhoitaja suosittelee ja kerroin tietenkin, mitä tytöt on puhunut mulle, sellaista viestiä terveydenhoitajalle."
>
> "We just had a long conversation the other day regarding these girls of mine, about what could be done with them. What does the nurse recommend and I told, of course, what the girls have told me, that kind of messages to nurse."

Primarily, nurse reserved appointments with a general fractioned. Need for other appointments with specialized care givers came out in nurse's basic interview or through minors' appointments with nurse. Doctoral services were mostly bought from private sector. If private health care providers did not have the expertise to provide specialized care, referral based services were used in public sector. For example in ophthalmology, surgery and mental health care. Also in acute cases, public services were used.

Care was said to be available for minors and counselors accompanied them to doctor if children so wished. Dental care was mentioned as an example of a worthwhile form of preventive care cost and efficiency-wise. In some cases, when according to reception center's professionals' assessment there was no need for an appointment with general practitioner on health basis; appointments were made to reduce the minors' anxiety.

> " --asiakas, joka valitti monesta vaivasta koko ajan --, hänellä oli semmonen käsitys, häntä ei hoideta ollenkaan ja ei ollut mitään tarvetta kävis lääkärissä, rauhoittamisen, lohduttamisen vuoksi lähetetään hänet lääkäriin."

> " – a client who complained about many disease all the time --, s/he had that kind of perception that s/he is not cared for at all and there was no need to visit doctor, in order to calm and comfort s/he is sent to the doctor."

After a minors visit to doctor, the follow-up care is the nurse's task. Professionals looked after children's intake of medication jointly. Some children resisted care. As an example, they were reluctant to take medication, counselors and nurse then motivated and encouraged them together to take their medication in time and to follow their care program. Professionals tending follow-up care gave the minors a feeling that they are considered seriously.

Participants stated that definition of acute and necessary care was unclear and it was not instructed precisely enough. Thus, reception center professionals had to determine by themselves what kind of services actually ought to be offered to minor asylum seekers and where to draw the limits.

Definition of acute care was also referred to as questionable. At times professionals felt that right for care or services available were limited or lacking and children in need of care were not attended. For example to receive mental health care services, a child had to be severely ill. Participants stated human rights to be important for them and not being able to help out was straining. Inhibitions for delivering care were seen as a question of resources or saving

money and human beings well-being should have been more important than that. Availability of services in preventive state of health were seen necessary, currently minors received care only when they were already severely ill.

> " -- nuori ei oo sosiaaliturvan piirissä, vaan on turvapaikanhakija, ei oo oikeutettu siirtää mihinkään lastensuojelupuoleen tai kuntoutuspiiriin. Täytyy odottaa ja se vielä lisää, niin kauan kuin on selvää itsetuhoisuutta. Ja se ei mun mielesä saisi olla näin pitkällä, tarvii mennä todistaa, että nyt olen paha itselleni tai yhteisölle."

> "– a youngster is not included in social security, but is an asylum seeker, there is no right to transfer to anywhere to child protection or to rehabilitation. You have to wait and that increases, as long as there is obvious self-destruction. And it shouldn't, in my opinion, take so long that one needs to prove that now I'm bad for myself or for the community."

7.3.2 Housing services for unaccompanied minor asylum seekers

Minor asylum seekers were housed in a reception center. Participants described this center as an old house in a remote area. Access to public transportation was difficult; therefore one of the services minors received was transportation to for example participate in hobbies.

Minors were said to be afraid in the beginning after arriving to reception center and adapted to circumstances gradually. Feeling of safety and peaceful state of mind were reported to be important both for getting used to reception center and for minors' health promotion. A characteristic of good housing service was open atmosphere that allowed minors to express their own opinions.

> " Huomaa joistaki uusista, et ne on vähän kauhuissan kun ne näkee jonkun ohjaajan ja nuoren semmonen kipakka keskustelu, et mitäs täst nyt tulee ja kuinka se nyt uskaltaa puhua tuolla tavalla. Ja sit huomaakin, et kaikki menee hyvin nii heilläki syntyy sit se luottamus--, et semmonen mielipiteiden ja tasa-arvoisuuden ilmaiseminen on niinku se henki on täällä hyvää."

> "You notice from some new ones that they are a little bit terrified when they see a sharp conversation between a counselor and youngster, that what's going to happen now and how does s/he dare to talk like that now. And then s/he

> notices that everything goes well and a trust is born also for them --, that kind of expression of opinion and equality that atmosphere is good here.”

Part of housing services, minors under 16-years of age were served readymade food. There was an expert chef that cooked the food and considered necessary nutritional components. Professionals reported healthy food to promote children’s health. Minors over 16-years-old cooked their own food, professionals supported them by teaching them how to cook, informing about healthy food, preserving it and hygiene-related issues.

7.3.3 Personal counselor

Every counselor had one to three named minors, whose personal counselors they were. Personal counselor’s role was to be aware of their named children’s needs and state of health, to acquire and share information about their children from other professionals. Personal counselor had an adult role in a minor’s life, in daily work it consisted of surveying a minor’s everyday life and then giving advice and helping out.

Personal counselor’s and a child’s relationship was closer than that of other counselors. Closer relationship was built through taking time for an individual child and showing that the professionals are not always in a hurry and are available. In addition to spending time together in reception center, counselor and child made excursions together.

> “ – meil on omaohjaajaretket mitä saa tehdä, siihen saa käyttää pienen summan rahaa, vaikka elokuvissa tai syömässä, muttet jotakin sellaista, et nyt me lähdetään yhdessä sienimetsään, tekee nyt hyvää tälle nuorelle, --“

> “ – we have personal counselor’s excursions which we can do, you can use a small sum of money for that, for example to cinema or eating out, something like that, we will go to forest to get mushrooms together would do good for this youngsters now, --“

However, lack of time within work was seen as an inhibiting factor for offering good quality personal counselor care. That led into lack of presence in a minor’s life, which they needed when feeling lonely and unsafe. Further, professionals’ commitment to care in general and role of personal counselor was said to be varying and not everyone made effort to have a

close relationship with a minor. As a conclusion, to have a personal counselor system was seen as a good way to offer care to minors.

7.3.4 Free-time activities for unaccompanied minor asylum seekers

Hobbies were part of minors' daily program. Hobbies were seen to support in maintaining daily rhythm and said to be therapeutic and helping children in forgetting their worries. According to professionals, participation helped to sleep better and in that way served to maintain the rhythm. Physical health is part of human's well-being, in addition to easing minors feelings, professionals recommended exercise or going for a walk to minors for example when they had headaches.

> " -- agressiivisuutta voi purkaa siihen pallolle, potkaisee, jouksee ja väsyy. Jos niitä rasitetaan niillä ei oo miettimisaikaa, väsyneenä menee nukkumaan. "

> " -- one can relieve aggression to the ball, kicks it, runs and gets tired. If you strain them, they don't have time to think, they go to sleep tired."

> "-- yritetty järjestää mielekästä touhuja, että ne ei kyllästy ja purkaa tuskaansa eri tavalla. Minusta se on meiän terapia niiden nuorten kohalla kun ei oo varsinaista terapiaa.

> " –- tried to organize meaningful bustle, so that they don't get bored and relieve their pain in a different way. In my opinion, it's our therapy for those youngsters as we don't have proper therapy."

Counselors organized hobbies, such as exercise, handcraft and excursions themselves according to children's interest, their own skills and resources available. Minors' commitment to hobbies varied and for some participation was difficult due to traumatizing experiences. Newcomers, in particular girls, were not necessarily aware of different types of hobbies and their personal interests. Thus one of professionals' tasks was to encourage participation and advice how to take part regularly.

> " Vaikea saada nuoria, joilla on traumoja takana, sisällissodassa pahoja kokeneita ja nähneitä, niin, että kaikki ei pääse meiän toimintaa aloittamaan harrastusmuotojen mukana, mutta pikkuhiljaa on päässyt—"

> ” It’s difficult to get youngsters, who have traumas behind them and have experienced and seen bad in civil war, so that not all can start to participate in our hobbies, but bit by bit they have arrived in—“

Despite lack of time, utilizing existing staff resources efficiently enabled to offer free time activities for minors, as there were not much resources for that area of work. Professionals considered these activities an important form of emotional support and promotion of physical health.

> “ Ei oo paljon resurssoitu, että saadaan näin paljon aikaiseksi, niin kuin sanoin kirjava työntekijöiden puolesta ollaan saatu mahdollistamaan näitä toimintoja.”

> ” not many resources have been used to achieve this much, as I said, because of colorful staff we have managed to enable these activities.”

7.3.5 Support in asylum process

Minors were said to be scared of officials, some had bad experiences in their country of origin and Finland was new, unknown environment for them. Every minor was appointed a legal guardian who pursuit their interest in the asylum process. In addition, social worker conducted an interview with minors and supported in their process.

Lawyer’s services were available for advice and in some cases lawyers requested a doctor’s statement on a minor’s health condition to support asylum application. Reception center’s nurse acted as a link between the lawyer and doctor. Interpretation services were available for minors during these official meetings.

7.4 Multi-professional co-operation for promoting minor asylum seekers’ health

Professionals presented diverse professional knowledge as a strength of their working community. Professional collaboration within reception center was mentioned by all participants’ as benefitting minors’ well-being. Three main forums of collaboration was reported of, firstly, daily report, secondly meetings and lastly networking with colleagues.

7.4.1 Professional communication and collaboration

Daily report was held thrice a day and was a forum for sharing information about minors' condition, behavior and health related symptoms. Nurse was present twice during working days and it was seen beneficial to stay up-to-dated about the minor's daily situation and how an individual's day had gone. Daily information helped the nurse to observe and promote minors health on an individual level according to needs and also to inform co-workers.

Secondly, three types of meetings handled among other things health related issues. Executive group's meetings dealt also with client related issues, definitions of policy were drafted and future functions discussed. Information was forwarded to staff's meetings, where professionals' client related concerns were discussed in turn.

Professionals and minors had meetings together where staff shared information with children for example about future events or health related issues. Children in return presented wishes, for example about activities and these where then discussed in staff meetings. Children's meetings were seen as a forum for minors to share their worries and for adults as a forum to offer safety through their presence.

> " – halutaan, että he voivat hyvin. Voiminen hyvin tarkoittaa, että halutaan heidän terveyttä. Heidän fyysinen ja myöskin psyykkiseen liittyviä asioita. Olla rauhassa, tuntea on turvassa, on aikuisia ympärillä. On väylä, jossa kertoa oma huolia ja on aikuisia jotka läsnä heidän kokouksessa. Myöskin johto on lasten kokouksessa läsnä."

> "– we want them to be well. Well-being means that we want their health. Their physical and also psychological related issues. To be in peace, to feel to be safe, to have adults around. There is a channel, where to tell about their own worries and there are adults who are present in their meeting. Also lead is present in children's meeting."

Thirdly, professionals worked together to promote minors' health and a network was involved in care. Understanding role of other professionals facilitated co-operation and care. Workers communicated to each others about children's state of health and needs, for example if someone needed particular attention or support.

> " – vaihdetaan tietoa nuoresta, keskustellaan nuoren asioista ja kerrotaan toisillemme mitä jollekin kuuluu. Jos ollaan huomattu, et jollain nuorella on

jonkunlainen olo tai vaiva, siirretään muille ohjaajille, jotka sit taas oppii huomioimaan sitä nuorta nyt erityisellä tavalla."

"– we change information about a youngster, discuss a youngster's issues and tell each other how someone is doing. If we have noticed that some youngster has some kind of feeling or sickness, we forward to other counselors who then again learn to give attention to that youngster in a particular way."

7.4.2 Diverse professional knowledge

Different educational and professional background was enabling to offer versatile services in reception center. As resources were seen scarce, utilizing staff's skills was seen as an addition to services available as well as an efficient and beneficial way of working. For example, language skills and professionals' ability to organize different hobbies were supportive for minors.

As minors originated from different countries, cultural knowledge was seen to facilitate care. In addition to professionals' language skills, diverse ethnic background was reported to be helpful in daily work. Professionals and children originating from same culture had a common way of handling things which brought a feeling of safety for minors. Further, staff member's personal experience as an asylum seeker gave an insight of life in reception center that was an asset to work.

" Meiän talon toiminta on erilainen johtuen siitä työyhteisö on erilainen. Työyhteisö on eri ammattia omaavia työntekijöitä, joilla on myöskin kokemusta itse olleena asiakkaana ja tällä hetkellä työntekijänä. Ymmärtää paremmin kuin toisessa vokissa, jossa työntekijöitä ei ollut sellaisessa roolissa."

"Function of our house is different due to our working community is different. Working community is composed of workers possessing different professions who also have experience of being a client him/herself and at the moment is a worker. S/he understands better than in another center, where workers have not been in that role."

7.5 Recommendations for improving minor unaccompanied asylum seekers' care

In addition to lack of resources presented above, two main concerns regarding minors' care arose from participants. Improvements in health care as a system and special education for network of professionals involved in care were suggested. Political decisions and changes in legislation were seen necessary in order to provide adequate care as for now complete access to services was granted only after an asylum seeker had received residence permit. Immediate service access after arriving to Finland was proposed.

7.5.1 Health care system

At the moment, minor asylum seekers access to health care services is restricted due to legislation. Additionally, waiting time for those services that were available was long, for instance, a minor had to wait for psychological specialist treatment even though nurse's services were seen to be inadequate. It was proposed that every child should be assessed by a general practitioner and by psychologist to recognize those in need of more profound support quickly.

Reception center was said to be restless environment and not suitable for those who were severely traumatized. Smaller reception units were seen necessary for some children because of their state of health. Further, centers should have a more homely environment in general to offer a feeling of safety for children.

Professionals recognized minors' need for psychological help and most of them were seen to need therapy. Children had traumatizing experiences of war such as rape, torture or losing close ones behind them. It occurred that even when diagnose was made by physician, the care that a child received was scarce.

Professionals proposed to have diverse mental health care services. Firstly, to have a specialized mental health care nurse working in reception center. Secondly, different kind of therapy, such as art therapy for younger and conversation based therapy for older children. Thirdly, a confidential peer support group that would function within the reception center could offer a place to share experiences, listen to others, become aware that one is not alone with his/hers experiences and peer support group would be available rapidly. More rehabilitation services and special services for victims of torture were proposed.

> “ – nuoria, joilla on traumaattisia taustoja, mielenterveysongelmia, kokeneet pahoja, näkevät pahoja asioita mitä on tapahtunut elämässä yön aikana, ihmiset ei pääse nukkumaan, tarvitsee monipuolisempaa hoitoo. Jos vaan katsotaan perusasiat ja ihminen on niin paljon syvässä ongelmassa eikä saa tälläisä mielenterveyteen tai kuntoutukseen liittyviä hoitoja.”

> “ – youngsters, who have traumatized backgrounds, mental health problems, have experienced bad things, see bad things that have happened in life during night, people can’t sleep, they need more diverse care. If you only consider basic things and a person has such deep problems and can’t get that kind of mental health or rehabilitation related care.”

7.5.2 Special education for professionals

Some participants stated they were surprised to know about minors’ bad past experiences and they did not necessarily think about them. Working with traumatized clients was seen as challenging, as it gave rise to feelings of helplessness, confusion and inadequacy. Professionals felt they could not do enough to help as they could not offer therapy themselves and lacked knowledge in general of how to work with traumatized children.

> “ -- mitä uskaltaa ja voi sanoa ja miten oikein pitäisi toimia. Meil ei siinä mitään osaamista. Sit vaan yrittää maalaisjärjellä toimii ja ymmärryksellä ja empatialla mitä siitä tulee, mennä vierelle ja kysyy haluut sä puhuu ja joskus se voi olla ohjaajalleki vaativaa, sielt voi tulla kauheen pahoja asioita ja et on ite hyvin hämmentynyt, et voi kauheeta, tollasta taakkaako sä kannat?”

> “– what does one dare to say and how should one act. We have no know-how in that. Then you just try to act through common sense and understanding and empathy that rises, go beside and ask do you want to talk and sometimes it can be demanding for the counselor, too, terribly bad things can come out and then you are very confused, awful, is that the kind of burden you carry?”

Participants mentioned that there was training available on health promotion and the center was involved in sexual education program. However, to support clients with mental health problems, more specialized training was seen necessary.

Psychological experts in Finland, too, lacked expertise in minor asylum seekers' special problems. It was proposed that awareness of trauma, effects of losing loved ones, being in an unfamiliar environment, cultural competence, and circumstances in children's country of origin would be components of clients' background that experts ought to have knowledge of. Currently experts were trained to address issues typical for Finnish society, for example divorce. Further, it was suggested to train experts originating from same countries with clients did to facilitate understanding and delivering care.

7.6 Recommendations for good practices

According to action research model applied in this study, in collaborative feedback step, participants commented on findings presented to them in form of initial recommendations. Participants' comments were then taken into account to further develop final recommendation for good practice. Three out of four initial participants responded.

In this chapter, final outcome of this research, recommendations for good practice (see Table 4), were discussed in relation to THL's main characteristics of good practice. Final recommendations were based on existing practices derived from interviews that were discussed in the light of literature review in chapter 8.3 Discussion of findings. In addition, professionals' proposals for developing existing care practices and service system are depicted under titles "Recommendations for developing care".

In collaborative feedback step, participants added recommendations for developing care. Being able to take more time to support minors with homework and going to school, shifting focus of personal counselor work to preventive care, organizing regular information sessions about Finnish society and equality in working with minors regardless to whether a professional shares a common language or not, sticking to role of a professional rather than a countryman were recommendations concerning work within reception center. Description of nurse's services was complemented by conversation-based support. Being able to communicate in their own language was said to be an asset of multiethnic working community as it offered a feeling of safety for unaccompanied minor asylum seekers.

Activity-based therapy, mental health care units especially for asylum seekers, and a monitoring system for interpreters' language skills, training and professional qualification were recommendations proposed for service system. Professionals' views on each minor's need to be assessed by a psychologist differed.

First of the five main characteristics set for good practice is functionality or effectiveness in its specific context and evolution to show good outcomes for user. Recommendations established in this research were based on professionals' participation and literature, this research did not focus on evaluation mechanisms used in reception center. While some of the recommendations were based on already existing practices, some had, however, not been yet implemented or evaluated as they were recommendations for developing care.

Secondly, a good practice ought to be ethically acceptable. Participants reported of ethical contradictions in relation to unaccompanied minor asylum seekers' access to specialized health care services, scarcity of mental health services and definition of acute and necessary care. Lack of time spent with clients in reception center instead of doing daily chores was challenging for some participants. Resources for work and service structure is, however, based on national legislation and dimensioned according to what has been adequate for minors. Generally, services offered and existing practices were seen as good in quality and health promoting.

Thirdly, versatile knowledge on effectiveness of the practice is a feature describing good practice. Information available in this research to cosititute good practice was professionals participation and other research related to this topic. No information of evaluating practices within reception center or clients' point of view were requested for in this study. Therefore, knowledge available to establish good practices is lacking in this part and ought to be an object of further research. This deficiency also hinders implementing fourth characteristic set enabling the reader to assess from what kind of knowledge effectiveness of existing practices are derived from and what are possible shortcomings.

Lastly, a good practice ought to be described concisely. Outcome of this research was aimed to be presented in a compact, easy-to-read form. Therefore, good practices are in form of a table, see TABLE 4 below.

TABLE 4. Recommendations for good practices

1. Health promoting practices in daily living	Existing practices	Recommendations for developing care
1.1 Emotional support by reception center professionals	Presence and availability of professionals as adults for minors Building trustful relationship between professionals and minors Closeness in a relationship between professional and minor Show that minor asylum seekers are accepted as any other children Take time to spend with an individual minor	More time necessary to support individual minors who are in need of emotional support Training for reception center professionals on working with traumatized minors
1.2 Guidance for minors	Individual information from professional to minor Group information for minors in children's and staff's common meetings Sexual education as a topic of guidance given by reception center professionals Guide minors to meet care professionals when in need Teaching how to cook healthy food and how to store it hygienically Teaching how to use income support in an economical way and purchase healthy goods	Regular information sessions concerning Finnish society
1.3 Housing services	Safe and peaceful housing environment Creating open housing atmosphere Support minors in expressing their own opinions Guide minors to meet care professionals when in need Healthy and nutritional food offered by reception center Transportation services to connect minors with surrounding environment and hobbies	Smaller reception units for severely ill or traumatized minors A specialized mental health care unit for minor asylum seekers Homely environment in reception center
1.4 Daily rhythm and routines for minors	Regular meal times Regular sleeping and wake-up times Going to school Taking part in free time activities Exercising	Free-time activities for smaller groups More resources for organizing free-time activities

2. Health care services for minors	Existing practices	Recommendations for developing care
2.1 Nurse's services	Basic interview with all new inhabitants of reception center, also those who transfer from another unit Active participation in daily report twice a day Active role in observing minors daily life Consultation for colleagues, minors individually, and minors in form of group information Co-operation in a minor's network of care Follow-up care and medication Reception centers' staff's joint responsibility of supporting minors in their care programmed through ensuring intake of medication and follow-up care Conversation-based support for minors	Mental health care nurse services available in reception center
2.2 Specialized health care services	Based on nurse's interview, appointment with general fractioned followed by specialized care if needed Counselors accompany minors to specialists to support if they so wish Focus on preventive care	Clear definition of acute and necessary care for delivering care for minors Changes in legislation to provide full access to care prior to receiving residence permit Every minor ought to have a needs' assessment by general practitioner and psychologist Immediate access to mental health care services Training for mental health care professionals on asylum seekers issues Training for specialized health care professionals from asylum seekers'' countries of origins Stable, state-based funding for mental health care services, continuation of project funding insecure Diverse mental health care services needed: - art therapy for younger minors - conversation therapy for older minors - peer-support group within reception center - rehabilitation services for victims of torture - activity-based therapy

3. Personal counselor work	Existing practices	Recommendations for developing care
	Appointed personal counselor for every minor	More time needed for personal counselor work with an individual
	Acquire information about minor from care network	A bigger share of time for personal counselor work in relation to other work tasks in counselor's job description
	Survey named minor's daily life closely	More time to support minors in homework and going to school
	Offer advice and help	Through observing a minor's daily living closely having an intervening work role and focus on preventive care
	Build a close relationship through taking time, caring and being available for a minor	
	Follow-up care and medication	
	Take individual time together outside reception center, for example excursions or going for a walk	
	Conversation-based support for minors	

4. Professional co-operation in reception center	Existing practices	Recommendations for developing care
	Daily report thrice, nurse participating twice during weekdays	Equality among minors regardless to whether professional shares a common language or not, sticking to role of a professional rather than a countryman
	Information flow between different types of meetings held in reception center (executive group, staff meeting and children's meeting)	Training for professional interpreters, specialization in mental health care related vocabulary
	Common meetings for minors and staff (children's meeting), offering minors a forum to express their ideas	Monitoring system for interpreters training, level of language skills, professional qualification
	Involving a network of professionals in a minor's care	
	Information sharing among staff about clients needs and state of health	
	Multi-professional working community to provide diverse services	
	Multiethnic working community to facilitate understanding of clients' and their cultures	
	Interpretation service use in official meetings	
	Professionals mastering clients' languages to facilitate daily communication and offer a safe feeling for minors to communicate in their own language	
	Professionals cultural competences to facilitate understanding with clients	

8 DISCUSSION

In the discussion part of this study, ethical considerations and trustworthiness were reflected on. Further, findings of this study were discussed in context of previous research and legislation regulating existing services and practices. Interests for future research are suggested. As an outcome of study, recommendations for good practices are drawn based on data (TABLE 4), including proposals for developmental needs in this field.

Some changes proposed for developing care would be possible to implement on local level in reception center, for instance, focusing more resources on personal counselor work or organizing regular information sessions. Some proposals would require changes on a national policy level, for instance training for mental health care professionals or establishing smaller reception center units for severely traumatized minors.

8.1 Ethical considerations

Throughout the action research process, ethical arguments should be part of the grounds for decision making. Kvale suggested that in the early stages of a study the researcher needs to consider the informed consent that includes estimation of possible benefits and risks for participants (1996). Polit & Hungler (1999) consider principals of doing no harm and maintaining human dignity and beneficence central in evaluating what kind of and how to undertake research. In planning phase of this study, it was decided to involve reception center professionals only, as minor asylum seekers undergo many interviews related to their process anyhow, it was thought to be somewhat straining for them and they are in a vulnerable state of life as such. This decision, however limits established good practices to some extent, as clients' point of view is an important part of quality work.

Research plan was submitted to reception center's director to acquire written permission (Appendix 1.3) and it was agreed that the name of reception center would not be published in this thesis. To maintain confidentiality, the researchers decided not to describe the center in great detail. This decision influenced analysis part somewhat, as more in-depth description would have allowed to illuminate findings in relation to existing resources such as housing facilities, location of the center or amount of staff which are all factors influencing services needed and available for minors. The amount of reception centers are limited in Finland, forwarding detailed information could have revealed the individuals or center in question.

Talbot (1995) has presented autonomy and non-malfeasance to be among main principals for nursing research. Accordingly, the principle of autonomy states that an individual is free to decide independently whether or not to participate in a research study. The principle of non-malfeasance states that no harm should come to a subject as a result of participation in this study. A participant is a volunteer and has the right to withdraw at any point of the action research process.

After receiving research permit, appointments were made with professionals working in that unit to participate in the interview. It was emphasized that participation is voluntary and in collaborative feedback one participant withdrew. Silverman (2001) emphasizes the meaning of informed consent, accordingly, it should provide information about the study for an individual to decide on his/ her participation and ensure that it is voluntary at all stages of research and that the participants understand the information.

In this study, information for participants was forwarded in Finnish language in written form to present the purpose and over-all design of action research briefly (Appendix 1.5). Participants had the possibility to ask more questions prior and during their interview and each signed a written consent (Appendix 1.7). As action research has a loop-like design, the participants had the chance to refine their statements and further influence the direction of the study's outcome.

The obligation of confidentiality was maintained throughout the study. It was guaranteed for the participants that any information they would disclose would not be reported in a manner that identifies the subject; they were assured that the information would not be made accessible to parties other than those involved in the study. The tape-recorded interviews and written answers were told to be destroyed as soon as important data has been gathered, analyzed, commented on by participants and finalized. While presenting participants' quotations in findings chapter the researchers had to decide whether to formulate the content, dialect or accent of an individual's speech to protect their identity within the center, as the number of participants was small and people working closely together may recognize their colleague's statements. No major changes were decided to undertake, as it could have changed the meaning of statements. Instead, it was decided to conduct collaborative feedback individually with each participant as in the initial interviews and it was not disclosed, from whose statements exactly initial recommendations originated from. Final version of the thesis was forwarded to the reception center where the interviews took place.

8.2 Trustworthiness

For the purposes of strengthening trustworthiness in qualitative research Granheim & Lundman propose scrutinizing a research through its credibility, transferability and dependability (2004). According to Talbot (1995), objectives of trustworthiness that need to be attained in a qualitative study are credibility, transferability, dependability and conformability. Credibility ensures the plausibility of interpretations and conclusions. It means the extent to which conclusions represent reality (Talbot, 1995). Graneheim & Lundman (2004) accented variation in participants' experiences on the subject, age and gender to facilitate gaining richer data. In this study, male and female professionals coming from Finnish and non-Finnish origin, some possessing asylum seeker background themselves and represented four different professions within the reception center.

Both researchers were working in a reception center during the time of this research. It was a beneficial starting point for acknowledging a need for conducting this study and a need to develop work. In addition to offering expertise on the subject of study, it also casted a shadow on the trustworthiness of this study. Starting from interviews, researchers' own assumptions may have unconsciously leaded the dialogue. Professional information obtained was, naturally, useful in understanding the phenomena and making follow-up questions. Challenging part of this research in the light of personal background information was analysis process. Inductive method of analysis, in particular, required an open mind in order to avoid personal presumptions and jumping into conclusions prematurely. Researchers seeked to minimize utilizing their prior knowledge at this stage through following Granehiem & Lundmans's (2004) data analysis method carefully step by step.

The interviews were conducted in Finnish language and material translated into English during the data analysis process when coding phase was reached. Quotations used among findings were captions from original transcribed interview texts and seeked to translate into English language carefully to maintain the content as close to original statements as possible. Initial recommendations were submitted to participants in English though not all mastered that language and were therefore depending on researchers' translation. Quotations from the participants' oral descriptions were included in the findings to provide factual data; also tapes of each participant's oral description were transcribed into written form to allow profound familiarization with the data. Collaborative feedback step of action research allowed participants to review whether the researchers had understood what had been said.

Graneheim & Lundman (2004) stated that credibility of research findings deals with how well categories formulated cover the data and the similarities within and differences between the categories. In this study, data was used to create meaning units, codes, sub-categories and

categories. No relevant data was systematically excluded or included; focus was laid on careful induction of categories.

Transferability means the extent to which a study's findings would be similar in another context. Transferability allows someone other than the researcher to determine whether the findings of the study are applicable in another context (Talbot, 1995). The findings in this study, as in any qualitative study, are unique; the result of the findings cannot be transferred to another context directly for purposes of generalization. If this study would be repeated in a different environment, for example in another reception center, the findings would probably differ somewhat. However, the outcome of this study can be used in this field of work if applied to strengthen health promoting practices in reception centers' professionals' daily work and in to discuss in the light of other research done in this field. Graneheim & Lundman (2004) recommend describing research's context, participants, data collection and analysis process closely in order to enhance transferability. Further, they emphasized the importance of presenting findings in depth, including quotations.

Dependability means that others can logically follow the processes and procedures used in the study and find the same or similar concepts, patterns and categories as in this research if given the same data, context and perspective (Talbot, 1995). Steps of the analysis were described carefully, to facilitate others than the researchers to follow the process and come to the same conclusions. In addition, to illuminate how findings were formulated, an example of data analysis process from coding phase to final category was presented (see Figure 4). Also for ensuring dependability, data analysis method was chosen and seeked to be followed carefully.

Conformability guarantees that the findings, conclusions and recommendations are supported by the data and that there is an internal agreement between the investigator's interpretations and the actual evidence (Tallbot, 1995). Discussion part has a key role in confrontability of this research. In addition to literature reviewed in theoretical framework, following action research model, a fresh review was conducted based on findings of this study. Relation of other research was described.

8.3 Discussion of findings

The purpose of this study was to find out how professionals promoted unaccompanied minor asylum seekers health in a reception center in their daily work, what were the content and methods of health promotion. Lastly, the purpose was to establish recommendations for good practices utilizing action research method. There were four participants in this study, who

were involved in research process in two phases, in initial interview and in collaborative feedback through commenting initial recommendations. In the first phase, inductive data analysis was used, in the second phase, participants' written comments directed changes made to produce final recommendations for good practice (see TABLE 4, p. 53). Here, these recommendations are discussed in the light of other studies related to this subject.

Consistent with the findings of this study, emotional support was seen as an important aspect while caring for unaccompanied minor asylum seekers. Several studies highlighted the importance of trust in establishing a supportive relationship between a professional and a child. Trust was one subcategory of emotional support in this study's findings.

A study carried out in Finland (Sourander 1998) pointed out that minors wished to have opportunity to discuss their situation and problems with adults they trusted. A trustful relationship and conversation-based support was seen to ease somatic symptoms, such as abdominal pain, headache and insomnia that were common among minors. Further, minors' ability to cope better was seen to be achieved through offering psychosocial support services that at the time being were lacking.

A study conducted in United Kingdom (Kohli 2006) presented emotional support for minor asylum-seeking children to be a foundation of a helping relationship that actually mattered in easing their distress. A helping relationship was built on trust, it was presented that taking care of practical worries first was a way to establish it. However, to really support a minor, a closer relationship could be built through listening and being available for preserving youngsters' bad experiences. In this study's findings, conversation and presence of an adult were elements of emotional support that are in accordance with Kohli's studies results. Käkönen (2010) found in her study focusing on counselors' psychological support for minor three core elements that were presence, conversation and action.

In a literature review on refugees' and asylum seekers' primary health care in the UK, Feldman (2006) mentioned that information about health services and advice on health promotion is needed in order the clients to benefit from services. According to findings of this study, guidance was one key aspect in reception center's daily services and offered in several forms and topics, both spontaneously along daily chores and pre-planned based on professionals' assessment of minors' needs. Sexual education was a topic identified by the professionals as necessary for minors, further, supporting daily rhythm was seen a crucial way to support health in daily work.

According to findings of this study, personal counselor work was seen as good practice for offering care, survey and to support minors through a closer relationship. These kinds of

relationships were seen to promote clients' health through helping in emotional and daily needs. A Finnish study on personal counselor work with asylum seekers had similar indications stating that it is an important service according to both clients and professionals in offering support, again, trust was mentioned as a key factor of a helping relationship (Eerikinharju & Vahtera 2011).

According to Sourander's research (1998), minors residing in reception centers felt a lack of activities. Kohli & Mather (2003) presented activities to be helpful as they kept unaccompanied minor asylum seekers busy and offered moments of ordinary life. Organizing free-time activities for minors was pointed out as a good practice in this study too, it was said to occupy their thoughts instead of worries and to support daily rhythm, which was seen as a platform for well-being. However, more resources were seen to be needed both for organizing activities and personal counselor work.

Findings of this study indicate to absence, limited access and lack of specialization in mental health care services available for minor unaccompanied asylum seekers. A clearer definition of acute and necessary care was also requested for, it was said to be questionable and vague currently. A lack of access to specialized social and health care services has been denounced in previous research (Käkönen 2010, Parsons 2009, Mikkonen ja työryhmä 2002, Sourander 1998), although it is stated that in principal health care services exist and should be available (Pirinen 2008, Mikkonen ja työryhmä 2002). Several recommendations for good practices in this study's findings focus on improving minor asylum seekers' mental health care. Diverse forms of care, needs assessment for psychological support and immediate access to care were proposed. In 2010, out of 330 decagons on asylum applications for minors 262 were positive (Finnish Migration Service 2011c). Those individuals would have benefitted from immediate access. Also, the costs of preventive care are lower than those of acute care. These recommendations established aim to facilitate the role of preventive actions in form of highlighting good practices in reception center professionals' daily work that promote health.

Similarly to Finland, in Australia too, access to mental health care services for young refugees was found inadequate (De Anstiss, Ziaian, Procter, Warland & Baghurst 2009). Further, a need for culturally competent or same-culture health care professionals was identified and it was proposed culturally sensitive services to be more likely acceptable to young refugees, particularly if interpreting services were included. According to a research focusing on mental health needs of refugee children in United States (Crowley 2009), linguistic barrier between health care professionals, and refugees' lack of knowledge about the nature and purpose of mental health care services as well as stigma related to mental problems are factors hindering participation and the quality in care. Also in this study, lack of common language was seen as a factor hindering quality of care, using interpretation services in official

meetings was appointed as a good practice and further development suggested to establish a training and monitoring system for interpreters.

Feldman (2006) supported utilizing bilingual staff in asylum seekers' and refugees' health care. He identified a need for training focusing on refugee and asylum related issues for health care and reception center professionals in his study conducted in the UK. Particular needs consisted of knowledge in mental health care, working skills with interpreters, understanding asylum system and cultural awareness.

In his study on physicians' and asylum seekers' encounters in Finland, Koehn (2005) found that there was only little correspondence in clients' and professionals' healthcare perspectives. Those professionals who had higher transnational competence also had more congruent perspectives with their clients resulting asylum seekers to trust more their physician's recommendations and having a stronger belief in future encounters. In this study's findings, professionals mastering clients' languages were seen as an asset for daily communication, multi-professionalism and multi-ethnicity were seen as facilitators in promoting clients' health. Further, training for both mental health care professionals and reception center professionals was proposed.

Two studies focusing on counselor work in reception centers in Finland depicted professionals' role within their working communities to be messengers for forwarding information about clients' well-being and needs to each other's (Eerikinharju & Vahtera 2011, Käkönen 2010). Also in this study, various forms of information sharing were disclosed as good practices. In addition, professionals' informative communication with clients, for example through common meetings was seen as a form of good practice.

This study limits in professionals' perspective only. No client perspective was taken into account. According to definition of good practices, client feedback and evaluation are components of good practices. Also in definitions of health promotion, an individual's own perceived ideas and actions are in central position in order to achieve change. These two perspectives were not studied in this research.

Although there are national instructions for reception centers and care, local circumstances, resources and practices vary somewhat from center to another, therefore, not all recommendations can be adapted for all centers. It is, however, possible to apply these recommendations for good practices.

Ideally, future research will include several reception centers in order to gain a wider perspective on good practices and enhance its adaptability in reception work overall in

Finland. As there are several different professionals working in a reception center, a deeper perspective on how each one can in his/her job description support clients can be researched. Most probably there are many other methods and good practices in addition to the ones recommended on the basis of this study’s findings. Also implementing these recommendations and evaluating them in practice, both by professionals and asylum seekers are indications for further research.

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APPENDIX 1.1 INTERVIEW THEMES IN ENGLISH

1. Background information

   Gender and age:
   Educational background:
   Related previous working experience:

2. Interview themes

   - Role and daily tasks in reception center

   - What kind of health supporting services are offered to asylum seekers

   - What is the content of health promotion

   - How do you promote asylum seekers' health in your daily work

   - Professional opinion on asylum seekers' health promotion in general

APPENDIX 1.2 INTERVIEW THEMES IN FINNISH

1. Taustatietoa:

   Sukupuoli ja ikä:
   Koulutustausta:
   Alaan liiittyvä aikaisempi työkokemus:

2. Haastatteluteemat

   -Rooli ja päivittäiset tehtävät vastaanottokeskuksessa

   - Millaisia terveyttä edistäviä palveluja tarjotan turvapaikanhakijoille

   - Mikä on terveydenedistämisen sisältö

   - Miten edistät turvapaikanhakijoiden terveyttä päivittäisessä työssä

   - Ammattilaisen mielipide turvapaikanhakijoiden terveyden edistämisestä yleisellä tasolla

Laurea University of Applied Sciences

PERMISSION FOR RESEARCH

Metsänpojankuja 3

02310 ESPOO

June 2010

Director

We are Master degree students in Health Promotion study program in Laurea University of Applied Sciences. Part of our studies is thesis work that focuses on asylum seekers' health promotion in reception center. Study is titled **"Unaccompanied Minor Asylum seekers` Health Promotion in Reception Center, Recommendations for Good Practice "**. The study aims by interviewing professionals and asking them to participate in commenting research data to establish recommendations for good practices.

Participation is voluntary and it is possible to withdraw at any point from the process. Our goal is to interview from 5 to 8 persons in Finnish. The interviews will be taped and the location for interviews will be selected together with participants. However, we ask permission to use reception center's premises for this purpose if necessary.

Reception Center or the participants will not be mentioned by name, nor shall their identity otherwise be revealed in the final report. Final thesis will be presented in Laurea University of Applied Sciences seminar, will be archived in school library, as well as in online database "Theseus". One copy will be sent to the reception center. No monetary compensation will be paid for participation in interviews. Please contact us for additional information.

Sincerely,

Manchula Mohanathas

Bachelor of Nursing

041-5013816

momanchula@hotmail.com

Evelyn Sõer

Bachelor of Social Services

040-0731412

evelynsoer@gmail.com

APPENDIX 1.4 PERMISSION FOR RESEARCH IN FINNISH

Laurea Ammattikorkeakoulu
TUTKIMUSLUPA
Metsänpojankuja 3
02310 ESPOO
Kesäkuu 2010

Johtaja

Olemme Laura AMK:n ylemmän ammattikorkeakoulun tutkinnon opiskelijat Terveyden edistämisen koulutusohjelmassa. Osana opintojamme tehtävä lopputyö keskittyy turvapaikanhakijoiden terveyden edistämiseen vastaanottokeskuksessa. Tutkimuksen otsikko on "**Unaccompained Minorf Asylum Seekers' Health Promotion in Reception Center, Recommendations for Good Practice**". Tutkimuksen tarkoituksena on henkilökuntaa haastattelemalla ja pyytämällä heitä kommentoimaan tutkimusaineistoa muodostaa suosituksia hyviksi käytänteiksi.

Osallistuminen on vapaaehtoista ja prosessista voi koska tahansa vetäytyä. Tavoitteenamme on haastatella 5-8 henkilöä suomeksi. Haastattelut nauhoitetaan ja haastattelupaikka valitaan yhdessä haastateltavan kanssa. Pyydämme kuitenkin lupaa vastaanottokeskuksen tilojen käyttämiseen tähän tarkoitukseen tarvittaessa.

Vastaanottokeskusta tai osallistujia ei mainita nimeltä, eikä heidän henkilöllisyyttä muutoin pyritä paljastamaan lopullisessa raportissa. Lopputyö esitellään Laurea AMK:n seminaarissa, arkistoidaan oppilaitoksen kirjastoon sekä verkkotietokanta Theseus:een. Yksi kappale lähetetään vastaanottokeskukseen. Haastattelusta ei makseta rahallista korvausta. Annamme mielellämme lisätietoja,

Ystävällisin terveisin,

Manchula Mohanathas
sairaanhoitaja
Puh. 041-5013816
momanchula@hotmail.com

Evelyn Sõer
sosionomi
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APPENDIX 1.5 INFORMATION ABOUT RESEARCH IN ENGLISH

Laurea University of Applied Sciences
Master's Degree in Health Promotion
Manchula Mohanathas & Evelyn Sõer
Phone: 040-0731412
Email: momanchula@hotmail.com, evelynsoer@gmail.com

INFORMATION ABOUT RESEARCH

Dear Participant,

As part of our studies at Laurea University of Applied Sciences, we would like to invite you to a study related to our thesis.

Master's Degree Program focuses largely on health promotion and that is also a central theme of our thesis. We would like to study how reception center's professionals promote asylum seekers' health in their daily work. Research will be carried out by interviewing participants one by one once. Analysis of all the interviews will form a basis of recommendations for good practices, for which participants are asked to give feedback. Thereafter, final recommendations will be established.

All responses will be treated confidentially; both in final recommendations and thesis, participants' identity will only be known by the researchers. Nor will the reception center be mentioned by name. Participation is completely voluntary and it is possible to withdraw at any point from the process. The interviews will take place in the summer and autumn of 2010 and will be recorded for later analysis.

Thus we are asking you to share your expertise with us, so that it can be more widely utilized!

Sincerely,

Manchula Mohanathas
Bachelor of Nursing

Evelyn Sõer
Bachelor of Social Services

APPENDIX 1.6 INFORMATION ABOUT RESEARCH IN FINNISH

Laurea AMK
Master's Degree in Health Promotion
Manchula Mohanathas & Evelyn Sõer
Puh.: 040-0731412
S-posti: momanchula@hotmail.com, evelynsoer@gmail.com

TIETOA TUTKIMUKSESTA

Arvoisa vastaanottaja,

Osana opintojamme Laurea AMK:ssa haluaisimme kutsua teidät mukaan opinnäytetyöhömme liittyvään tutkimukseen.

Ylempi AMK-tutkinto keskittyy isoilta osin terveyden edistämiseen ja tämä on myös opinnäytetyön keskeinen teema. Haluaisimme tutkia, miten vastaanottokeskuksessa työskentelevät ammattilaiset edistävät turvapaikanhakijoiden terveyttä päivittäisessä työssään. Tutkimus tehdään haastattelemalla osallistujia yksitellen kerran. Analyysinä kaikkien haastattelujen perusteella muodostetaan suositukset hyviksi käytännöiksi, joihin osallistujilta pyydetään palautetta. Tämän jälkeen lopulliset suositukset muodostetaan.

Kaikkia vastauksia käsitellään luottamuksellisesti, sekä lopullisissa suosituksissa että opinnäytetyössä osallistujien henkilöllisyys jää vain tutkimuksen tekijöiden tietoon. Vastaanottokeskusta ei myöskään mainita nimeltä. Osallistuminen on täysin vapaaehtoista ja prosessista voi vetäytyä milloin tahansa.

Haastattelut ovat kesällä ja syksyllä 2010 ja ne nauhoitetaan myöhempää analyysiä varten.

Pyydämmekin siis teitä jakamaan ammattitaitonne kanssamme, jotta sitä voidaan laajemmin hyödyntää!

Ystävällisin terveisin,

Manchula Mohanathas
Sairaanhoitaja AMK

Evelyn Sõer
Sosionomi AMK

INFORMED CONSENT

I give my consent to participate in this study and to use the results of an interview in a Master's degree's final thesis for publication. My identity will be kept secret.

Signature and date

Print name

TIETOINEN SUOSTUMUS

Annan suostumukseni osallistua tähän tutkimukseen ja luvan käyttää haastattelun tuloksia Ylemmän ammattikorkeakoulututkinnon lopputyössä julkaistavaksi. Henkilöllisyyteni pidetään salassa.

Allekirjoitus ja päivämäärä

Nimenselvennys