Osaamista
ja oivallusta
tulevaisuuden
tekemiseen

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Promoting and supporting the health needs of asylum seekers and refugees in Finland

Literature review

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There has been a global increase in recent years, especially in Finland since 2014, in the number of people needing asylum. Due to this mass migration, nurses will need more guidance in the health care of asylum seekers and refugees in Finland. The purpose of this study was to first establish the most common health problems of asylum seekers and refugees and then investigate what kind of nursing practices can benefit health care professionals in Finland when caring for this vulnerable group.

An integrative literature review was carried out using nine articles selected from the databases CINAHL, PubMed and MEDLINE. The selected articles were analysed using the principles of the inductive content analysis method.
The results yielded were compiled into two main headings depending on which research question they answered. Then subheadings were compiled. The common health problems were found to be mental illnesses, chronic illnesses, gynaecological and reproductive needs, lack of preventative health, abuse and other contributary factors affecting health such as living standards or poverty.

The nursing practices found to be beneficial were; improvement of communication and interpretation, specialist training for nurses, techniques to improve cultural competence, giving support to each other and collaborative multidisciplinary teamwork, increased preventative health measures and screening.

These findings can be used by healthcare professionals to develop and implement interventions that can guide nursing practice in order to improve nurses' knowledge and skills therefore enhancing the quality of health care for asylum seekers and refugees living in Finland.

Keywords	Asylum seekers, refugees, nursing practices, cultural competence

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Turvapaikan hakijoiden määrä maailmalla on noussut viime vuosina ja Suomessa etenkin vuodesta 2014 alkaen. Lisääntyneestä maahanmuuttajien määrästä johtuen sairaanhoitajat tarvitsevat lisää neuvoja ja ohjeistusta turvapaikan hakijoiden sekä pakolaisten hoitotyössä.
Tämän opinnäytetyön tarkoituksena oli arvioida maahanmuuttajien ja pakolaisten yleisimmät terveysongelmat ja tutkia mistä hoitotyön menetelmistä terveydenalan ammattilaiset hyötyisivät eniten tämän haavoittuvaisen ryhmän hoitamisessa.

Interaktiivinen opinnäytetyö toteutettiin käyttäen yhdeksää eri artikkelia, jotka valittiin tietokannoista CINAHL, PubMed ja MEDLINE. Valitut artikkelit analysoitiin käyttäen induktiivisen sisällön analysoinnin periaatteita. Saadut tulokset jaettiin kahteen pääryhmään riippuen mihin tutkimuskysymykseen ne vastasivat. Sen jälkeen määriteltiin alaotsikot. Yleisimmät löydetyt terveysongelmat liittyivät mielenterveyteen, kroonisiin sairauksiin, gynekologisiin ja
seksuaaliterveyteen, ennakoivan terveydenhuollon puuttumiseen, väärinkäytöksiin sekä muihin ulkoisista tekijöistä liittyviin tekijöihin, kuten köyhyyteen ja alhaiseen elintasoon.
Hyödylliset hoitotyön menetelmät olivat kommunikaation ja tulkkauksen parantaminen, hoitajien erikoiskoulutukset, kulttuurillisen kompetenssin parantaminen, toisten tukeminen, moniammatillinen yhteistyö, ennakoivien terveystarkastusten lisääminen.

Näitä löydöksiä voidaan käyttää ammattilaisten hoitotyössä kehittämään ja parantamaan Suomeen tulevien maahanmuuttajien ja pakolaisten hoitotyön menetelmiä ja siten takaamaan heidän paras mahdollinen terveydenhuolto.

Avainsanat	Turvapaikan hakijat, pakolaiset, hoitotyön menetelmät, kulttuurinen kompetenssi

Contents

1 Introduction

There has been a sharp influx in the rate of refugees and asylum seekers arriving in Finland plus the rest of Europe in recent years. This is due to globalisation and ongoing conflicts worldwide. Individuals having been persecuted or as a result of conflict are needing asylum (UNHCR 2015:2). Consequently, it is inevitable that nurses will be working closely with refugees and asylum seekers. However, nurses feel unqualified to specifically help this clientele (Hogg 2010:165). Challenges such as mental health issues or somatic health issues caused by conflict, or the migratory process itself exist. Also, there can be cultural or language differences that need to be considered as these can affect the dynamics of the nurse -client relationship and therefore the nursing process (Taylor 2008:52). Nurses hope for more guidance and tools in their profession.

The purpose and aim of this study will be to find out what the mental and physical health problems of this client group are and how we as nurses can improve nursing practices in Finland to provide optimum holistic care for these individuals living here.
In the broader sense, by carrying out this thesis and increasing knowledge among Finnish health care professionals about best nursing practices, we aim to reduce the health problems among asylum seekers and refugees and promote a better health care service for this clientele group.

Research has been undertaken regarding physical health and psychological issues (Hogg 2010) and Taylor (2008). However, there are limited studies regarding nursing practices that can be used to improve the nursing care of this client group.

Initially, reception centre operations in Southern Finland were handled almost entirely by the City of Helsinki, but reception centres were opened in Espoo and Vantaa in the Autumn of 2015, mostly by private operators such as Luona oy. The City of Espoo is responsible for the reception of asylum seekers who are minors and travel alone. Reception centres have also been opened elsewhere in the Uusimaa Province.

In a survey conducted by Migri (2020) the Finnish Immigration service, at reception centres for asylum seekers and refugees, clients generally felt satisfied with their treatment care and

stressed the importance of the reception centres. The clients emphasised the need for further assistance in practical everyday matters and practical education in using their own skills.

Refugees and asylum seeker families warrant special focus. Families have to adapt to a completely new strange environment. Simultaneously, waiting for a decision on permission to reside is stressful, as well as the circumstances one faces at a reception centre. For parents, these factors can make taking care of a child's and their own wellbeing challenging. Therefore, the role of organisations that carry out activities with asylum seeker families or refugees is critical. The support, education and activities can for example support the families in learning about life in Finland and the integration process.

2 Purpose, Aim and Research Questions

The thesis purpose is to carry out a literature review to understand the health requirements of these families to provide nurses with a comprehensive view of their health needs and useful nursing practices. According to Coughlan et al. (2013:17) and Whitmore and Knafl (2005:548), a literature review gives a holistic understanding of some concept that can then be implemented in nursing practice or research for example.

2.1 Research Questions

1. What kinds of psychological and or other chronic or acute problems do refugees and asylum seekers have?
2. What nursing practices can we implement to provide optimum ongoing health care for this clientele?

3 Previous Research

3.1 Definitions

A *refugee* is a person who is fearful of persecution and does not feel protected in their own country (United Nations, 1951).

A person is recognized as an *asylum seeker* if they are waiting on approval regarding their refugee status. (Hogg 2010, 167.)

Culturally competent care is concept model developed by Papadopoulos, Tilki and Taylor in 1998 (Papadopoulos 2008:10). Cultural competence is giving individuals optimum treatment and taking into consideration their unique behaviours, belief and holistic needs (Papadopoulos 2008:10).

The model, is developed from being sensitive to other's beliefs, being aware, having background knowledge about the person. Professionals working in healthcare can listen to the client's perception of their needs and make a plan that would incorporate both the nurse's and the client's perspectives. In this way, the client is actively involved in their own healthcare. (Papadopoulos 2008:18- 20.)

3.2 Families with children

These families constitute an overwhelming number. Children make up more than fifty percent of those individuals having to leave their home countries because of conflict (UNHCR 2020). Children could be having trauma, mentally scarred or physically not in good health because of the home country situation, or because of migratory problems (Hogg 2010: 178). There may be incidences of malnutrition or disease. Or some children may show signs of neglect or some kind of abuse. There could have been such problems in refugee camps (Hogg 2010, 173). Trauma can present itself somatically. Symptoms such as headache, or stomach-ache can be prevalent amongst children (Saari, 2012, 264). Also, the parents have been through so much that daily tasks may have been neglected. On a positive note, children can adjust and adapt more efficiently, integrating into the culture more easily than the parents. There could be family tension because of this fact (Hogg 2010, 180). Hogg (2015, 167) says that separation during migration can occur. It can be difficult separating the health needs of child individuals and their families. The individual health of each family member greatly impacts the general health of the whole family.

Hogg (2010:174) notes that there is no worthwhile evidence in how to nurse those with psychological issues. However, The Victorian Foundation for Survivors of Torture based in Australia, have made a guide for those health professionals working closely with refugees (Foundation House 2012). England has some special nursing services aimed at refugees, for example, the National Health Service (NHS) Foundation Trust in Bolton (2015) and also The Teaching Hospitals in Leeds (2015).

The Finnish National Institute for Health and Welfare (THL) have been gathering data concerning the physical and mental status of asylum seekers. They have emphasised the importance of preventative health and also the need for sexual plus reproductive education as many arriving in Finland are in their fertile years (THL, 2015.) The Maamu study (2011) has helped THL focus on evaluation of migrants from Russia, Somalia, Syria and Turkey. They noted that this client group would very much like to have a job. However, the Diaconess Institute of Helsinki (2010) are aware of some having traumatic symptoms and not being aware of them themselves.

3.3 Consequences for Health Care

The scale of this ongoing crisis will definitely have a global impact on how we can give optimum care. Hogg (2010:165) states that “some professionals may feel lost dealing with the issues concerning this client group”. Taylor (2008: 58) and Hogg (2010:170) give the impression that the health level of this population is lower than that of the local population. Carrigan (2014:25) mentions that families in Australia originally from Syria or Afghanistan for example, have conditions such as PTSD or are not getting enough of the D vitamin leading to deficiency. Tuberculosis could be prevalent (Carrigan 2014:25). However as mentioned previously, this client group have a lower overall average age than the local inhabitants making them naturally healthier (Taylor 2008:58; Hogg 2010:167). Conditions of a psychological nature like stress or depression or anxiety disorders are likely to be more prevalent among this client group. However, normal stress caused by war, for example, is not the same (Taylor 2008:58). Although psychological issues can be common, many can endure strenuous situations without succumbing to symptoms of psychological illness and so therefore we should not stereotype without a diagnosis from a qualified doctor.

Kemp (2008:358) explains that refugees experience three different phases of adjustment; the acute phase, transitional and resolutory. In the acute phase, contagious diseases such as tuberculosis and hepatitis B are of worry. In the second transitional period, the focus is on how to tackle chronic conditions or psychological issues arising. The resolutory phase is characterised by then resolution of health problems but unfortunately the inaccessibility or unawareness of options available for refugees can lead to an ongoing or escalating chronic condition. (Kemp 2008:358.)

Taylor (2008:55) summarises stages that refugees go through and can have similar health issues to people of a lower economic class, as well as other issues concerning their experiences of being a refugee. Also, the country that they are originating from may have minimum focus on prevention of health. Hogg (2010:170) mentions that refugees may not be up to date with their vaccinations and therefore more likely to catch diseases. Significant numbers could have experienced torture and therefore make them more scared of any hospital or health care situation reminding them of previous negative situations (Hogg 2010:171).

3.4 Dealing with Culture Shock

As well as any health issues migrants might have when they arrive in a foreign country, they must also go through the integration stages of adaptation to the new environment and country. This could cause stress. Integration includes for example; the language, local customs or habits and diet. Simultaneously, the person could feel isolated if they have travelled alone and had to leave close family members behind (Hogg 2010:166). They may experience lack of finances, discrimination of some sort in their host country, not able to join the work force or find accessibility to health care difficult or have lengthy detentions impacting the quality of health greatly. (Hogg 2010:173). Carrigan (2014:24) reports that this client group will require help in order to get used to the very different health care systems in the West, for example being more actively involved in one's own health through empowerment of knowledge, so that they can make informed decisions. They also talk about how this particular client group are sometimes found to have diabetes for example and they are completely unaware of it.

3.5 Dealing with Cultural Hindrances

When healthcare professionals are working in a multicultural environment, there can be a multitude of obstacles preventing the provision of optimum care. These obstacles could be the language barrier or the differences in culture. Using interpreters can help (Taylor 2008:61). It is of no surprise that more effective screening and referral can enhance care quality and continuation of care if there is effective communication in the nurse client dynamics (Taylor 2008:61). Kemp (2008:362) mentions how student nurses working in the community can be actively involved in helping this client group. For example, they can help them make appointments and make them aware of the services available (Taylor 2008:52). Hogg (2010:165) says that despite putting a refugee and an asylum seeker in the same category, they will quite often have differing needs and backgrounds with hardly anything in common. Taylor (2008:60)

emphasises it is most important to consider patients holistically and equally as individuals even though we should have an idea about their cultural background.

3.6 The Finnish Situation

Nurses will more than likely be working closely with this client group. Finland has been taking about 750 individuals every year since 2001. In 2014 this figure increased to 1050 because of the situation in Syria (Migri 2015.) In 2015 there were approximately 4,000 applications for asylum. Of this figure, about 300 were children who were unaccompanied by an adult. Reception centres here like Luona Oy provide the basic health care services which are free (Hoitopaikanvalinta 2015).

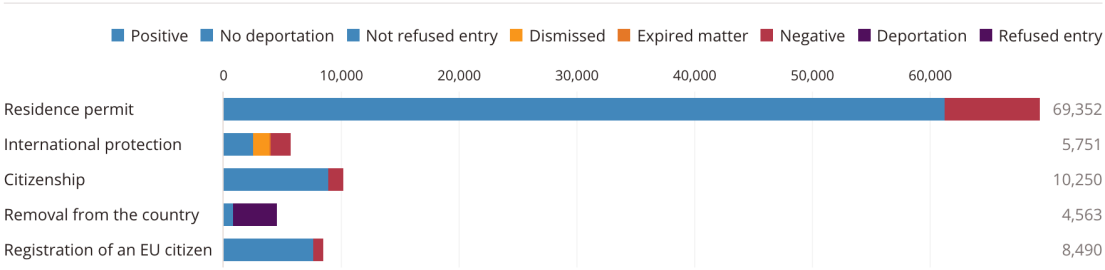
According to Finnish law, a refugee over 18 years of age can access acute care if necessary. Refugee children have access to all health services (17.6.2011/746 §26; 30.12.2010/1326 §50; 1.12.1989/1062 §3). Screening or vaccinations are not compulsory, only in the case of suspected tuberculosis. On arrival here in Finland in the first two weeks, they should receive information about all the services available to them. Refugees are able to use all public health facilities when the status of refugee has been declared (Hoitopaikanvalinta 2015.)

3.7 Current Statistics in Finland

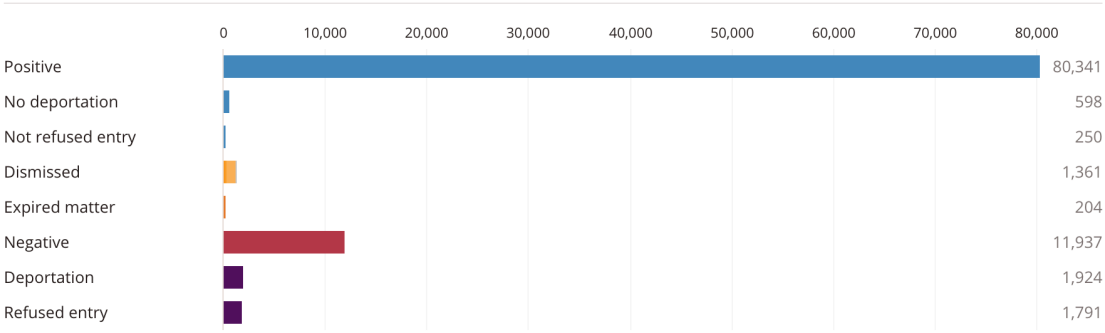
The statistics in Figures 1- 5, show decisions made by the Finnish Immigration Services in the last twelve months. However, these statistics concern immigration figures in general including refugees and asylum seekers. It seems that 70,5% acquired a residence permit; 81% receiving a positive decision; about 50% were between the ages of 18 and 34 years old; from top migratory countries such as Russia, Iraq, the Ukraine, India, China, Vietnam, Afghanistan and Somalia, and about 56% being male.

- Finnish refugee statistics for 2019 was **23,473.00**, an **increase** of **5.28%** from 2018.
- Finnish refugee statistics for 2018 was **22,295.00**, an **increase** of **7.64%** from 2017.
- Finnish refugee statistics for 2017 was **20,713.00**, an **increase** of **12.56%** from 2016.
- Finnish refugee statistics for 2016 was **18,401.00**, an **increase** of **44.86%** from 2015 (Macrotrends.net 2020).

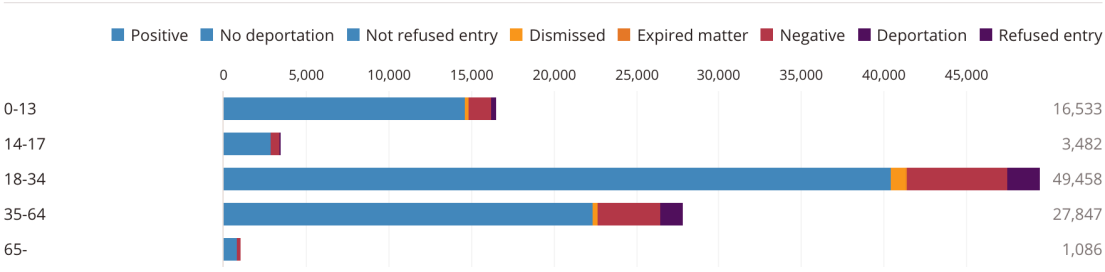
3.7.1 Applicant groups – Figure 1



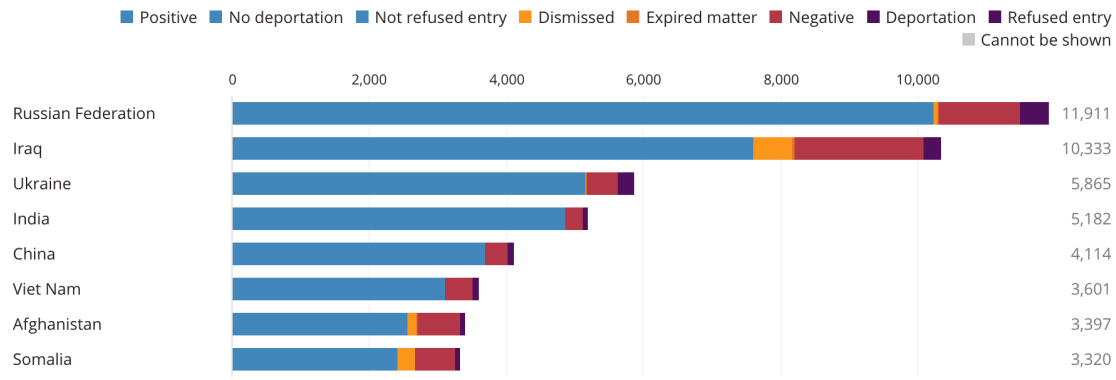
3.7.2 Distribution of decisions – Figure 2



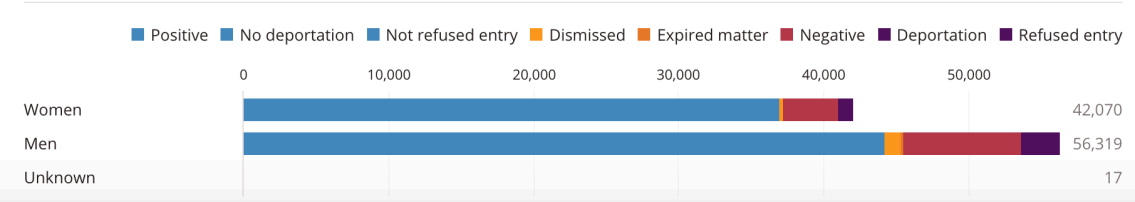
3.7.3 Age group – Figure 3



3.7.4 Citizenship – Figure 4



3.7.5 Gender – Figure 5



Finnish Immigration Services (MIGRI, October 2020).

4 Methodology

4.1 Descriptive Integrative Literature Review

The descriptive literature review method will be used for this thesis. A literature review starts by summarizing existing evidence -based information on the topic chosen and then aims to pinpoint research related to the study questions, critiquing and analysing the results obtained (Coughlan, Cronin & Ryan, 2013). Development of the subject contents and themes form the basis of the research study (Stolt, Axelin & Suhonen, 2016, p.7). The aim is to understand the given subject by forming a connection of the results obtained or finding other interpretations of the subject. This is carried out through the analysis and synthesis of the articles (Coughlan, Cronin & Ryan, 2013, pp.14-15). This proves to be important in giving a general overview to the professionals and is important in the future development of nursing with regards to evidence -based practice (Aveyard, 2010; Coughlan, Cronin & Ryan, 2013).

In a literature review, a wide focus is achievable and can include both qualitative and/or quantitative research. (Coughlan, Cronin & Ryan, 2013, pp. 14-15.) A thorough description of the method which is carried out systematically can be repeated over and over again (Aveyard, 2010; Stolt, Axelin & Suhonen, 2016, p.7). Explanation should be given of the search terms and how they have been developed, the variables for the literature search, selection of literature, and the analytical process. This shows that the criteria for selection and analysis is valid and reliable. Literature bias is less probable (Coughlan, Cronin & Ryan, 2013, pp. 14-16). The author will carry out the same systematic way in this literature review.

4.2 Database searches selected

Articles looking at the health needs of asylum seekers and refugees plus how we can support and promote their healthcare were searched using the electronic databases MEDIC, CINAHL, PubMed and MEDLINE. Access was acquired through Metropolia University of Applied Science's LibGuides pages. MEDIC has special access to Finnish literature. Initially CINAHL and PubMed were searched, and key terms were compiled. When appropriate articles were found, more specific terms and themes were utilised to form a more specific search. The MeSH (Medical Subject Headings) and CINAHL headings were then used to assemble the themes found. The Boolean operators "AND" and "OR" aided the search. It was aimed to limit the search to the last ten years, and to find articles in English or Finnish only. Only articles that could be accessed via Metropolia and did not require any payment were used in this study.

The research questions naturally guide the process of the literature review's inclusion and exclusion criteria.

Figure 6. on Page.10 shows the Data selection process. 84 articles were found in total; 65 from PubMed and 19 from CINAHL. 40 articles were discarded immediately as they did not meet the inclusion criteria. The remaining 44 articles were read through thoroughly. 35 articles were subsequently discarded because the articles were not specifically about asylum seekers or refugees. 9 articles were selected in total according to the inclusion and exclusion criteria shown in Table. 1 on page 11.

Figure 6. Data Selection Process

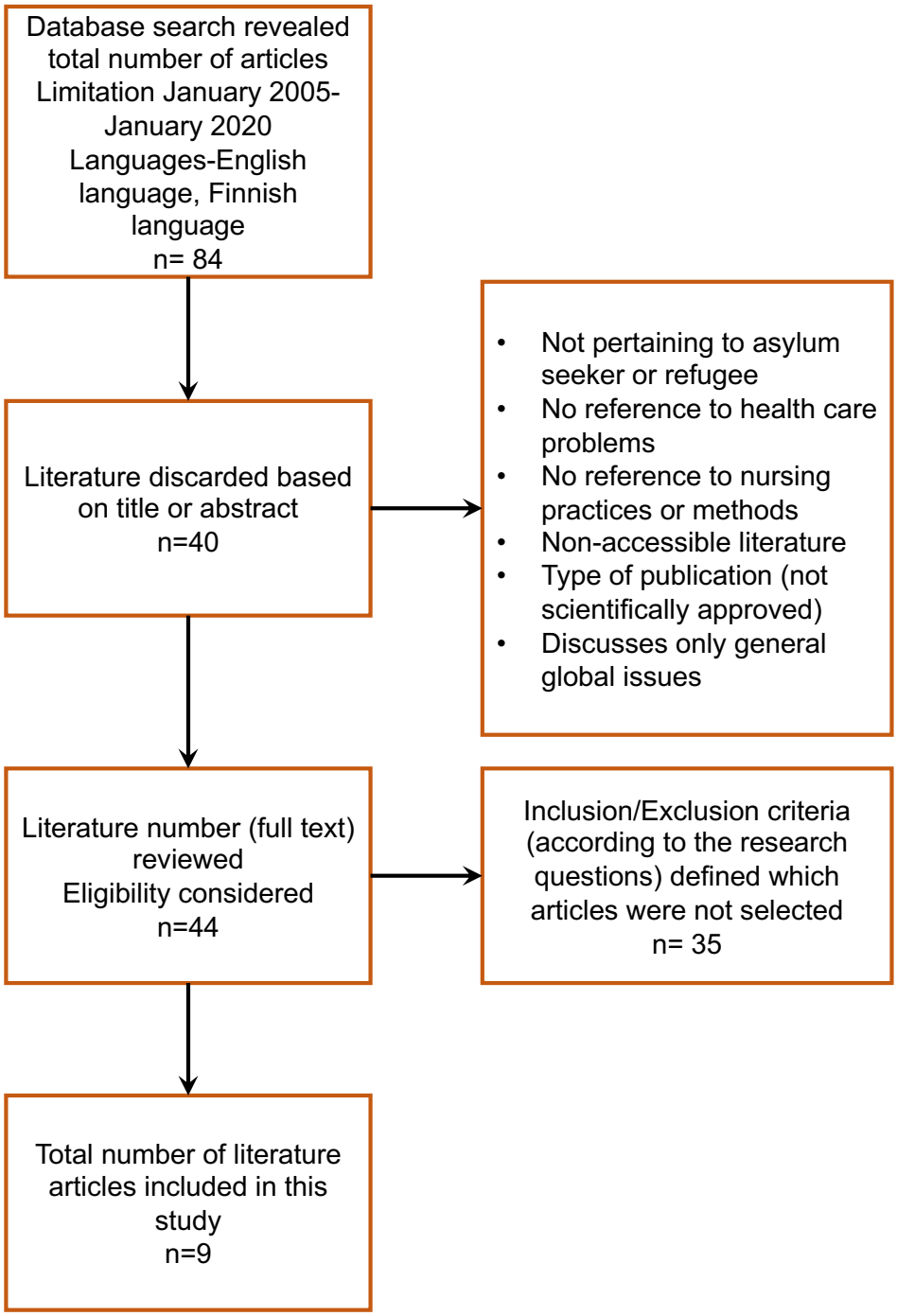


Table 1. Inclusion/ Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Article answered either both or one of the research questions	• Article did not answer either research question
• Article available as full text	• Full text was not available
• Focus of the article was on asylum seekers or refugees	• Focus of the article was on immigrants in general
• Language used was English or Finnish	• Literature was carried out in another language other than English or Finnish
• Article could be applied to all areas of nursing care	• Article only focused on specific nursing care, for example mental health nursing
• Literature could be qualitative, quantitative or both	• Publication type
• Literature used from January 2005 to January 2020	• Literature considered too old, published earlier than January 2005

4.3 Data Analysis

It is important to have clearly structured research questions as one of the biggest tasks is the process of going through a large and varied amount of literature (Whittemorer and Knaflk 2005:548). In the analysis stage, the literature must be sorted into subgroups (Whittemorer and Knaflk 2005:549). The literature was sorted into the type of research, for example quantitative, qualitative or mixed method studies. Data was then sorted into themes. According to Thomas (2003:2) analysis of data is using an inductive approach. However, it uses both deductive and inductive elements (Thomas 2003:3). Information will be sorted according to which of the two research questions they are answering. This is the deductive stage.

The inductive stage will be carried out by thoroughly reading through the articles many times and deducing relevant information. Subgroups can then be found. The advantages of this

technique is that an enormous scope of literature can be summarised (Thomas 2003:2). Significant patterns start to emerge which can then be compared and contrasted. Conclusions of the analysis can then be seen (Whittemore and Knaflk 2005:551.) This method is used by undergraduates carrying out literature reviews and is also used if the references include both research studies and non-research studies. There can be some bias when interpreting the data, but the method is a systematic process which concludes in a summary of the literature (Coughlan et al. 2013:97.)
The results can be seen in Table 2 on page.13.

5 Results

5.1 Introduction

There were 9 articles altogether. 5 were qualitative studies, one was a quantitative study, there were two case literature articles and one article that incorporated both qualitative and quantitative research. The research was carried out in these countries; USA, Switzerland, U.K and Ireland. Unfortunately, no Finnish research was included in the selection process. Appendix 1. summarises each article.

5.2 Summary of results

Table 2. provides a summary of the major key information obtained and the subgroups and is divided by the research question.

Theme	
Research question 1; Physical issues	**Research question 2; Nursing practices**
Psychological illnesses • post- traumatic stress disorder (PTSD, trauma, anxiety disorders **Somatic illnesses** • chronic conditions, for example hypertension • lower back pain and other skeletal problems **Sexual and reproductive health** • pregnancy and delivery • unwanted pregnancies and abortion • sex education **Abuse issues** • sexual or physical • domestic violence • child maltreatment **Impacting contributary factors** • poverty/destitution • isolation, loneliness • stresses linked to migration • in some instances, using own medicine • not complying with care or medication • prevention for example, lack of immunizations	**Helpful nursing** • visits to the home, community facilities • screening, prioritisation of problems faced • using community to aid • more emphasis towards sex education and psychological issues • ongoing individual holistic approach **improving nurse-client relationship** • extra time, clear instructions, using drawings, diagrams • listen, actively present • interpreters more widely used • qualified and health knowledgeable interpreters **Recommendations for education** • more emphasis on culture • how to overcome psychological trauma • providing information on legality or KELA issues **Techniques nurses could use** • enquiring about person's culture, using it in the care • be open to individual's own ideas and ways try not to stereotype an individual or assume • using nurses with same roots **multi-disciplinary teams** • cohesive teamwork • therapeutic guidance for workers • shared information

5.3 General Health Problems

The five different sub-themes for the first research question were; psychological illnesses, somatic illnesses, sexual and reproductive health, abuse, and contributary external influences. The articles chosen from the data analysis discussed the different psychological issues, those being anxieties, PTSD, and other traumatic problems. Physical illness seems to have been researched to a less extent than psychological problems, but Bischoff et al. (2009:60) reported that common issues related to health were ongoing, more so than acute problems. Diabetic problems, or hypertensive problems were found to be the typical chronic health issues (Springer et al. 2010:7; Bischoff et al. 2009:60). Gynaecological and reproductive health needs were also recognized as necessary, also there were incidences of sexual assault and child maltreatment (Burchill 2011:25; Paris et al. 2006:38; Kurth et al. 2010:4.)

Contributing influences were addressed in the literature and it is clear that a focus should also be on contributing influences leading to poor health. Burchill (2011:25) mentions that destitution, because of isolation was apparent. Loneliness and isolation were mentioned in other literature for example in the study by Paris et al. (2006:39). Stress because of migration can also influence the health in a negative way (Kurth et al. 2010:7).

Preventative health measures are an unfamiliar concept to many asylum seekers families (Springer et al 2010:9), for example, immunisations are not always up to date (Kell et al. 2005:31; Beatson 2013:144). The refugee will sometimes want to use their own traditional home medicine, and this can be a benefit in some cases. (Springer et al. 2010:6.) Some refugees may not always be compliant, and this could be because they do not fully understand explanations given to them (Kell et al. 2005:31). Some may be receiving contradictory information from those closest to them (Springer 2010:9).

5.4 Nursing Practices to be implemented

For the nursing practices that could help (research question 2), five subthemes arose: helpful nursing practices; suggestions for improving nurse-client relationship, recommendations for education, techniques and multi-disciplinary teamwork. Home visits were recognised as numerous articles as being valuable, for example Springer et al. (2010:8) and Kell et al. (2005:33). According to Paris et al. (2006:40), Springer (2010:8), Bischoff et al. (2009:63) and Drennan et al. (2005:159), an important reason was because screening could take place earlier and diseases could be picked up on earlier rather than later and peer groups arranged

(Drennan et al. 2005:160; Paris et al. 2006:43; Kell et al. 2005:33). Community organisations could provide families with support.

Kurth (2010:4) and Bischoff et al. (2009:63), emphasise that psychological wellbeing and sexual education were areas that needed more priority. According to Drennan et al. (2005:161) and Paris et al. (2006), ongoing continuous holistic relationships were vital, and family centred care the aim.

Effective communication and its challenges were discussed. Kurth (2010:8), Beatson (2013:144) and Springer at al. (2010:8) considered the relevant idea of using more time and having a relaxed atmosphere to give explanation when and if needed, as well as use of necessary diagrams, pictures, videos, interpreters etc. can only help in effective communication. Tobin et al. (2014:166) says that instructions should be succinct and to the point, with diagrams if necessary. Paris et al. (2006:44), considers the concept of listening actively. Many articles for example, Kell et al. (2005:31) and Kurth et al. (2010:10) validated the importance of using qualified interpreters with health knowledge.

Health care workers wanted more training in order to cope with the challenging situations they encountered. Beatson (2013:142), Drennan (2005:161) and Tobin et al. (2014:163) said that they especially wanted cultural training, training to help patients suffering from psychological issues or training in dealing with legal issues for a particular country. Drennan et al. (2005:159) say that nurses can be more active in asking about the client's culture and try to accommodate their wishes as much as possible.

Stereotype avoidance was also pinpointed by Springer et al. (2010:8). Being able to use nurses of a similar background was also mentioned as important in helping the refugee families by Paris et al. (2006:45) and Kell et al. (2005:31). Beatson (2013:144) states that the client's own methods are okay if they are medically approved and do not contradict the care plan or goals. Articles such as Burchill (2011:26) and Kurth et al. (2010:7) referred to the complex and emotional nature of working with these families. Kell et al. (2005:30) suggest that multi-disciplinary teamwork was an ideal way to alleviate this. Paris et al. (2006:40) argued that more emphasis should be placed on emotional help and guidance for health care workers and Drennan et al. (2005:162) recommended sharing information with peers.

6 Discussion

6.1 Most common health issues

According to the analysis of the literature, health issues apparent include psychological issues such as PTSD, types of anxiety and chronic problems. Mental health problems were more apparent than any of the physical concerns. This is to be expected if thinking about the experiences they have endured. Kurth et al. (2010:5) talks about traumatic past events and the link to stress. Hogg (2010:171) states that asylum seekers may have endured torture and therefore hospital procedures may trigger unpleasant memories.

Also, living conditions in their host country can produce stress, for example unpredictability about the future or living separately from other family members. (Kurth et al. 2010:6). One health visitor said that she almost anticipated that the person would have some mental health issue due to their situation. Bishchoff et al. (2009:61) noted that post -traumatic stress disorder was high but transmissible disease was not prevalent. However, Kemp (2008:358) finds that the opposite is true, especially with regard to Hepatitis B or tuberculosis on arrival. Continuation of care and especially health care prevention must be the priority.

The Finnish health care system allows only emergency health care for asylum seekers (17.6.2011/746 §26; 30.12.2010/1326 §50; 1.12.1989/1062 §3). Burchill (2011:24) and Drennan et al. (2005:159) say the needs can be complex and it is vital to think about the basic requirements also. THL (2015) acknowledge that health needs as well as health problems should be considered. For example, THL (2015) mentions that sex education for refugees is necessary as they are considered fertile because of the age when coming to Finland. Kurth et al. (2010:8) states that the abortion rate is more than two times higher than the local population. Hogg (2010:171) says there may be little to no focus on health prevention from those countries from which the asylum seekers are coming from. This reinforces that there is definitely a lack in health promotion and prevention.

Stress or uncertainty of future life can lead to health risks increasing. Burchill (2011:24) discusses the impact of being socially isolated or being poor on parenting skills and how it can influence child development. Those health care professionals interviewed in Drennan et al. ’s (2005:160) study, mention the importance of addressing isolation by educating refugee mothers about community activities and organisations.

Integration into the new country and community is key because according to Drennan et al. (2005:160), various forms of abuse and also isolation or loneliness are prevalent. Information needs to be easily accessible and understandable. The reception centres such as Luona Oy mentioned previously can make a huge difference when arranging activities and peer groups for the families staying there, so that they would have some daily structure to their life and possibilities to integrate better into the Finnish way of life. For example, the importance of the children playing outdoors in safety in the fresh air for two hours a day may be very hard for some families who have come from a war -torn country to implement.

6.2 Commonly Used and Suggested Nursing Approaches

6.2.1 Helpful Nursing

Home visits provided many benefits to this client group. Tobin et al. (2014:168) states that community nursing can provide better nurse- client relationships, enhance continuous care and encourage access. Paris et al. (2006:39) mentions how the Visiting Mums Group was useful in providing a role model and also practical information or friendship. This research shows consistency with Kemp (2008:362), who states that visiting the client in their own home is effective in detecting health concerns in under- served, unreachable communities. Also, Taylor (2008:52) validates that poor communication could also be part of the reason, for example if refugees are unaware or if the service is inaccessible due to the communication skills. Home visits would make it easier for families to access health services. However, this makes the resource demand high. However, the cost burden that progressive chronic conditions place on the health service must also be taken into consideration.

Springer et al. (2010:8) summarised that the refugees studied only came to the accident and emergency department when acutely ill and having more home visits would increase awareness of chronic diseases. Kell et al. (2005:33) states health screening and prioritising needs is of paramount importance. Paris et al. (2006:40) in the Visiting Mum's Program assessed some factors like for example depression, isolation and abuse risk.

Drennan (et al. 2005:159) noted that workers put the health of children over the health of their mothers. In an ideal situation, all health needs could be addressed. However, it seemed apparent from the articles that due to the complex needs, the inability to maintain relationships and not enough workforce, workers could only do the bare minimum necessary to fulfil the basic needs of the client. According to the Finnish system, the adult asylum seeker can only

access acute health care (17.6.2011/746 §26; 30.12.2010/1326 §50; 1.12.1989/1062 §3). Drennan et al. (2005:160) mentions how community care reduced forms of social isolation and they tried to go with the women to the initial meeting. Also, Paris et al. (2006:43) explains that health visitors provided the link that connected the woman to their local organisation, for example, getting them to take part in English lessons. Community groups for women can educate mothers about childhood problems, as well as target health needs simultaneously (Kell et al.2005:33).

Health care professionals can be made aware of the fact that most do not have any form of mental health issues (Hogg 2010:173) and likely distress in tough situations does not necessarily lead to any mental pathology (Taylor 2008:58). However, research indicates that there should be more emphasis on psychological health in the refugee community. Bischoff et al. (2009:63) points out that psychological illness could be underestimated due to lack of communication and shame or taboo within the community.

Bischoff et al. (2009:63) stresses that new nursing models of care for treating chronic conditions, and psychological illnesses need to be developed. Tobin et al. (2014:166) stated that if there was no form of psychiatric help, then the health care workers would not raise issues relating to traumatic experiences. As one method of efficient nursing practice, Paris et al. (2006:40) states that in the Visiting Mums Program, the health professionals have had training in identification of trauma, it's effects and how to tackle it.

Kurth et al. (2010:10) propose free contraception. THL (2018), state that the population of those arriving in Finland are fertile in age so we must take education of sexual and reproductive needs into consideration. Hogg (2010:177) and Tobin et al. (2014:166) recognized that pregnancy and childbirth was a sensitive period as women may not have received effective antenatal care or for example a nutritious diet due to various circumstances. Drennan et al. (2005:160) talks about how important it is to maintain long-term relationships as it could take many years to build the trust necessary to deal with issues such as trauma.

Kemp (2008:358) says that refugees experience three stages of adaptation, psychological health issues generally arising in the second stage which could be several years after the refugee has arrived in the country. Bischoff et al. (2009:63) also recommends a continuous nursing care framework and Drennan et al. (2005:161) mentions utilising interpreters in an ongoing nurse- client relationship. On the Visiting Mums Program in Paris's study, there was a three- year nursing support plan set up. Kell (2005:32) believed that a continuous holistic

approach meant cooperative work between the family and other multi -disciplinary health team members having equality in the relationship leading to a more active role for the client, empowering the family and more effective compliance with any treatment. Empowerment for the family being of utmost importance, and especially empowerment through knowledge and providing activities.

6.2.2 Improving interpretation and communication

Research indicates that some aspects of health care services may be unfamiliar, for example immunisation programs, chronic diseases and some may not be aware of the existence or availability of services (Carrigan 2014:27; Taylor 2008:52). Extra time for this clientele group to explain concepts must be emphasised. Springer et al. (2010:8) reinforces the possibility of misunderstanding or miscommunication and some terms had no meaning at all, for example inherited disease.

The use of an interpreter to give precise instructions or the use of picture and storytelling were found to be the most helpful (Springer et al. 2010:8). Beatson's (2013:144) group needed repetition and clear instruction so that the medical terms made sense. Kell et al. (2005:33) recommended the use of translated leaflets and also sometimes information presented audially or visually for those parents unable to read. Tobin et al. (2014:163) said that written information in very few languages was available and there was no material available for those illiterate families. In an ideal situation, individuals from various backgrounds should receive information or material that is appropriate to them (Papadopolus 2008:16).

With tightening of public financial expenditure, it could be difficult to provide the necessary material in various languages. However, the key to empowerment is through effective communication channels (Papadopolus (2008:16). Poor verbalization and explanation could lead to poor client- nurse relationships therefore making consent for example difficult (Tobin et al. 2014)

Communication works both ways. This information can be verbal or non-verbal information, and sometimes one can contradict the other. Tobin et al. (2014:42) says we need to listen to the client and take into account their beliefs and listen to their fears and goals, this is providing culturally competent care. Paris et al. (2006:42) reiterated how important it is to make more

available the use of qualified interpretation services. Tobin et al. (2014:162) said that sometimes midwives had to use a family member to act as interpreter. This could compromise privacy and also safety.

Beatson (2013:144) talks about parents feeling frustrated when their own children were used as interpreters. According to Papadopoulos (2008:16-18.), this is not culturally competent care. However, Drennan et al. (2005:159) reports that it is ok if it is the only choice available. However, if family members cannot help, then there can be the ethical dilemma of unmet patient's needs or carrying through with a procedure for example that the client does not understand. Tobin et al. (2014:162), highlights worries about the translation accuracy. Springer et al. (2010:9) found that it was hard to come by interpreters who had enough health knowledge and Kurth et al. (2010:6) finds that sometimes anybody has been used to interpret.

Nurses will have to continue to make compromises between unidealistic alternatives. Hopefully, interpretation will become an inclusive part of holistic culturally competent nursing care Tobin et al. (2014:162) and Kurth (2010:10) advocate round the clock interpreters with specific health knowledge as mandatory. Drennan et al. (2005:159) argues that phone interpreters could be widely used as it is much easier nowadays with mobile phones. The interpreter's ethnicity could be of relevance if the client comes from an area of ethnic conflict.

Kell et al. (2005:31) says that we can use members of the refugee community as interpreters, especially if they are highly respected. Kurth et al. (2010:8) mentions that successful cooperation between mental health care workers and interpreters as well as the extra time allowed in consultation led to better standards of health care for the refugees.

To summarise, the findings stress the importance of overcoming language barriers by providing the necessary information using good quality translation (Taylor 2008:61).

6.2.3 Training recommendations

Tobin et al. (2014:164) reported in their study that the midwives had not received training. Kurth et al. (2010:10) said that as well as education in culture, professionals need education on identification and treatment of psychological issues. In Drennan et al.'s study (2005:161) more information was needed on the asylum laws, the client's individual customs or culture and also what strategies to implement with this client group. Health care workers do not have

the necessary tools to meet the needs medically or socially (Hogg 2010:165). Staff received training on the Paris's Mum's Program in areas such as trauma identification, abuse screening, parenting and cultural sensitivity. Mentoring was also provided, and challenging experiences discussed (Paris et al. 2006:37).

6.2.4 Techniques for improving cultural competence

The client's perspective of their problem must be incorporated into the care plan. Also, the client can actively participate in their own care plan and set achievable goals (Papadopoulos 2008:18.). From this literature review, we can see some of these methods were applied practically. Drennan et al. (2005:159), states that health professionals listened to the mother's views about the feeding. In Beatson's (2013:144) study, health workers aided parents in traditional healing methods.

Tobin et al. (2014:165) says that midwives thought it strange at first when mothers were wanting to move around during childbirth expecting the health worker to be present all the time. After some time however, the health workers became more open in their outlook. As long as there is no contradiction between traditional practice and evidence- based practice, it was found safe to include those alternative methods in the care of the mother.

Previous research suggested gaining specific knowledge about a group such as historical, geographical or sociocultural but not to stereotype (Papadopoulos 2008:11-13). Drennan et al. (2005:159) state that we must listen with an eagerness that shows that we are interested in another's culture or beliefs. Culturally competent care in Drennan et al. 's (2005:159) view is a combination of elements which incorporates also non -factual ideas about the culture, minimising stereotyping. The Papadopoulos, Tilki and Taylor model (Papadopoulos 2008:10) addresses similar ideas of stereotyping.

Tobin et al (2014:164) warns health care professionals about positive stereotyping, for example breastfeeding going well for a certain group and therefore making others feel undermined if they needed extra help and encouragement. A way to bridge the gap between families and health care workers would be to use those health employees with a previous refugee status.

Paris et al. (2006:42) saw this on the Visiting Mums Program when they used staff with the same backgrounds or cultures to support the refugee families. In this study, the workers were

qualified in trauma assistance and were treating refugees who had suffered a similar experience to which they themselves had gone through. Drennan et al's (2005:158) study had nine health workers who were previous immigrants. There are a multitude of benefits in using local community members as interpreters (Kell et al. 2005:31).

In Finland, this idea could be incorporated, providing an advantageous resource in helping new refugees find their feet. There would be enhanced communication. Paris et al. (2006:40) stresses that in order to protect their own well-being, these health care professionals would require some psychological guidance or counselling in case the situation provokes some reliving of past traumatic experiences.

6.2.5 Multi-disciplinary teamwork

Effective multi- disciplinary teamwork is key in nursing. Paris et al. (2006:43) have described this importance in their study when there was teamwork between health workers, paediatricians and psychotherapists for example. The health worker may sometimes have a combined role of coordinator plus interpreter (Kell et al. 2005:32). Burchill (2011:26) talks about teamwork in child protection. Tobin et al. (2014: 164) says extra work can be involved in the work with asylum seekers for example, trying to find interpreters.

Negative feelings could arise towards this client group because of communication or emotional issues (Kurth et al. 2010:6). Interpreters may feel troubled if they have to constantly listen to terrible stories (Kurth et al. 2010:7). There must be improved emotional help for workers, with regular meetings and team support.

No prior training, or team help made the workers feel helpless in certain situations. At the end of a shift, some nurses felt sad and worried as well as helpless for the clients (Tobin et al. 2014:165). Workers on the Visiting Mums Program in Paris et al.'s (2006:44) work had monthly feedback sessions with the superior. This is invaluable. Drennan et al. (2005:162) stresses the importance of shared knowledge. Health workers sometimes have to improvise when faced with challenges. In order to establish optimum models of nursing practice, it is necessary that individuals working in health care can share expertise on all levels; institutionally, nationally and internationally.

6.3 Limitations and Validity of research

We can evaluate through validity and reliability the research quality. Validity when thinking quantitatively, seeks to investigate whether the chosen method is measuring the intended data. When thinking qualitatively, research validity correlates to data interpretation. This could create some bias. For example, this thesis was carried out by one person and this could automatically lead to bias in the conclusions found.

Reliability is how cohesive and sound the chosen method is or are. Quantitatively, reliability is evaluated by how replicable the research is, whether using the same methods would produce the same outcome. Qualitatively the main tool used is the researcher, so reliability is usually not possible.

When carrying out this literature review, the author tried to gain approved evidence- based research, keeping methods integral for example when carrying out the induction process. The thesis can be measured by looking at criteria such as; how dependable it is, how credible it is and how transferrable it is. (Holloway & Galvin, 2016.)

As this whole process will be conducted by one person, there will always be a small discrepancy for human error. This was a small- scale study with only nine articles reviewed and some articles were more than ten years old, although they were relevant to this study. The author will strive not to be subjective and will endeavour to work objectively when carrying out this thesis.

6.4 Ethical Considerations

One must follow the rules laid out in the conduct of research. During all areas of the working process, the author has considered criteria such as; how accurate, honest, integral, open and responsible the work is. (The Finnish Advisory Board on Research Integrity, TENK 2012, p. 30.)

Some important research or findings in this work could have been unintentionally omitted. This is because articles were selected according to their availability. Bias in selection should be avoided and it is hoped that the most relevant articles have been chosen. However, not all available literature necessarily needs to be reviewed. (Coughlan et al. 2013: 16). A plagiarism program called Turnitin will be utilised at various stages throughout the work. In the last

Turnitin Check, done when the work was more or less finalised, the percentage score was 4%.

Ethically speaking, results must not be construed intentionally or unintentionally misinterpreted or misrepresented as this could be misleading. Credit must be given to all other sources of work used. (Logan University: Learning Resources Center, 2015.). The thesis results should be valid and reliable, meaning that if the method and subsequent analysis process would be undertaken by others, conclusions would be more or less the same.

Golafshani (2003:604) states that "Reliability and also validity are conceptualised as being made up of how trustworthy, how rigorous and the quality in qualitative paradigm." A process called triangulation can be effective in enhancing both reliability and validity in a qualitative study. A literature review naturally incorporates triangulation because we are looking for convergence, meaning that findings become more valid when various researchers carrying out varied methods reach similar conclusions. (Golafshani 2003:604.)

Guidelines for the responsible conduct of research (RCR) were used. These guidelines are published and updated by the Finnish Advisory Board on Research Integrity (TENK). The main goal of these RCR-guidelines is promoting reliable, credible, and ethically approved research. Adherence to the same RCR-guidelines therefore improves the quality of research. (TENK, 2012.)

All nurses have an ongoing professional obligation for continuous development in their careers. (Sairaanhoitajaliitto, 1996.)

7 Conclusion and Recommendations

The findings of this thesis have highlighted and stressed the importance and necessity of long-term ongoing care for refugees and asylum seekers in order to tackle chronic health, and psychological health. They require support with regards to preventative health and also support with access to health care. Sexual education is also necessary, and this includes childbirth and pregnancy.

Effective communication is key, and interpreters should be used especially if they are of good quality and have some health knowledge. Optimum care can be achievable for this challenging

group if the health team are getting enough psychological help and the specific training from peers and knowledge is shared.

One weakness of this thesis may that some articles addressed midwifery and health visiting. However, this confirms the necessity for sexual and reproductive education for these clients. Even if the results are not necessarily directly applicable, nurses can still benefit from what has been learnt in the steps encountered by midwives and health visitors.

It was also hard to find Finnish research. This would have been interesting. However, the conclusions drawn can be applied here in Finland and help guide health care professionals when working with asylum seekers or refugees.

Finding articles particularly related to refugee families was also difficult, but as mentioned earlier, if we can focus on the separate health issues of each family member, we can empower and make the family stronger as a whole.

The importance of the reception centres for refugees and asylum seekers was brought up and the recommendations for more activities especially peer group work. This would certainly help with such problems as isolation and loneliness as well as providing peer support for each other.

According to the news station here in Finland, Yle (2019), the Finnish National Institute for Health and Welfare (THL) have organised a national expert centre whose aim is the promotion of mental health in Finnish residents with a previous asylum seeker history. The main aim of this centre is to offer education and consultation to those health care professionals working in mental health, in the needs of refugees and simultaneously develop services for health care. This offers support for professionals from various areas to share knowledge and support each other. This is a prime example of multi-disciplinary teamwork using shared knowledge in order to promote health care for refugees and asylum seekers in Finland. THL (2019) talks about a 'central competency centre.'

After conducting the literature review, it became apparent that there are many challenges for nurses still when working with this client group and it was not easy to find any scope for effective nursing practices and to know whether health care workers had been successful in implementation of good nursing practice. There were some benefits to nursing practice in Paris et al. 's (2006) study and also in Kell et al. 's (2005) study.

All articles chosen had valuable information because of the practical work done, on how to advance towards developing care practices. Future research would benefit from these studies. Further research should focus on the specific needs of this target group. Drennan et al. (2005:162) says that 'health care officials should attend to the unique health requirements as well as fundamental needs'.

It is vital that we give emotional guidance and advocacy to the individual within the health care system whilst also maintaining enough psychological and practical support for the health care professionals involved in the care of this vulnerable group.

In doing this literature review we can help nurses gain knowledge about this unique group and the challenges they face. Hopefully, the results will also stimulate health care professionals to find competent nursing solutions that incorporate the cultural perspective so that we can provide optimum nursing care for this special clientele. Afterall, they have the right to the best quality health.

Below is a summary of the health care recommendations.

- Language Needs
    - documentation of literacy and language of refugee or asylum seeker
    - communication in the language the individual person knows best
    - use of interpreter
    - longer appointment times
    - simplified diagrams and pictures

- Mobility of asylum seeker or refugee
    - easy access for all professionals to medical documentation
    - copies of material given to client if referred to secondary care or treatment
    - regular ongoing contact
    - follow up
    - screening for homelessness.

- Health Service Requirements
    - catching up with immunisations within one year
    - high risk group testing for HIV, Tuberculosis or sexually transmitted diseases
    - screening for health issues such as history of torture, homelessness

  - reproductive education and childbirth education for refugee and asylum seeker families
  - mental health support
  - screening for chronic illnesses

- Staff education
  - cultural competence training and awareness
  - working with interpreters
  - multi-disciplinary team working

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Appendices

Appendix 1 Articles selected for literature review

Author(s), year, country of study, title, publication, volume	Purpose	Participants	Method, data collection and analysis	Main Findings	Conclusions and recommendations
1. Beatson, J. (2013), USA Supporting Refugee Somali Bantu Mothers with Children with Disabilities. Pediatric Nursing 39(3) 142-145.	Gaining an understanding of how local Somali Bantu refugee mothers with children who have disabilities perceive education or health needs of their child.	5 Somali Bantu mothers and 1 father	Grounded theory qualitative method. Semi structured, open-ended interviews. Analysis by coding and categorising into themes. Also, realist tales were included.	The study population is at high-risk of significant health problems.	Highlighted the need for good communication with refugee families and better understanding of the refugee experience by nurses in order to improve health outcomes.
2. Bischoff et al. (2009) Switzerland Health and Ill health of asylum seekers in Switzerland: an epidemiological	Finding out the most common diseases amongst asylum seekers.	979 asylum seekers enrolled in the Swiss Health	Quantitative data from the Swiss Health Maintenance Organisation.	The most common health problems were musculoskeletal diseases, respiratory diseases, depression and post -traumatic stress disorder. One-fifth of the	Most common health conditions were chronic rather than communicable acute diseases suggesting that the focus of refugee health

study. European Journal of Public Health 19(1), 59-64.		Maintenance Organisation program in 2000- 2003.	Descriptive statistics were used to assess common health problems and average numbers of health visits. Analysis was used to determine if age, gender or region of origin was significant in the results obtained.	population did not request any health care during the period.	care should be on continuous continuity of care rather than acute emergency care.
3. Burchill (2011), UK Safeguarding vulnerable families: work with refugees and asylum seekers. Community Practitioner: The Journal of the Community Practitioners' & Health Visitors Association. 84(2): 23-26.	Describes the experiences of health visitors working with refugees and asylum seekers in London.	4 health visitors	In depth interviews, transcribed and analysed using the Framework method.	Health visitors' experiences indicated that domestic violence, depression, child neglect, destitution and poverty were significant health problems in refugee families. Asylum seeking women and children were trapped in a cycle of abuse and often disappeared from the system completely	Practitioners must raise concerns with managers. New ways of cooperative team working to prevent and alleviate difficulties when working with this vulnerable group
4. Drennan et al. (2005), UK Health visiting and refugee fami-	Describes the experiences of health visitors working	13 health visitors experience working with refugee	Individual semi-structured interviews. Analysis using the	Health visitor experiences indicated that post -traumatic stress disorder and depression were	Strategies for working with refugees and asylum seekers, for example taking extra time to explain

lies: issues in professional practice. Journal of Advanced Nursing 49(2), 155-163.	with refugee families in London and investigates their perceptions of effective strategies to address the health needs of this client group.	families (including 9 immigrants)	Framework method.	common among refugee mothers. Health visitors would prioritise the needs of children before women. The health visitors felt unprepared to address the needs of refugee families.	services, use of community organisations and good practice using interpreters were mentioned, but were not developed enough and coordinated at an organizational level. Shared knowledge was recommended. Helping and informing refugee families on how to access services was a key aim.
5. Kell et al. (2005), UK Collaboration in eczema care: a case study. Pediatric Nursing 17(4), 30-33.	the benefits of a teamwork approach between a refugee family, their GP, health visitor and interpreter to improve health.	One refugee boy	Case study	Community nursing, a collaborative approach and effective communication through interpretation lead to significantly improved health outcome for the boy and his family.	Effective collaborative teamwork leads to significant health benefits and makes more efficient use of limited resources.
6. Kurth et al. (2010), Switzerland A reproductive health care for asylum-seeking women - A challenge for health professionals. BMC Public Health 10, 659-670.	Finding out the reproductive health issues of young women seeking asylum in Switzerland and what kind of care they are receiving	80 women	Mixed method: semi-structured interviews with health care professional and quantitative descriptive data from patients' records Quantitative data was analysed descriptively and qualitatively by	The abortion rate for asylum seekers was 2,5 times higher than the local population. Health professional workers reported language barriers and emotional challenges when taking care of asylum seekers.	Suggestions for improving care of asylum seekers included use of professional interpreters, support and training for health care personnel and more emphasis on psychological care and needs.

			Grounded Theory		
7. Paris et al. (2006), USA A home-based intervention for immigrant and refugee trauma survivors: Paraprofessionals working with High-Risk Mothers and Infants. Zero to Three, 27(2) 37-45.	Case study describing a home-visiting program targeting refugee and immigrant new mothers. The multilingual or bilingual home-visitor 'paraprofessionals' were immigrants and mothers themselves.	105 first time new mothers, average age was 28 with three quarters being under 30.	Qualitative case study including a description of home-visiting program.	Substance abuse, anxiety, depression, post -traumatic stress disorder, trauma, child neglect and isolation were noted as health problems in refugee and immigrant families. The benefits of 'paraprofessionals' working as role models and advocates were greatly valued. Also, the value of screening and prioritizing high-risk families was discussed	Authors highlight that the case study demonstrates the valuable benefits of using well-trained and well-supervised 'paraprofessionals' who are also mothers and members of immigrant communities to work with refugee families with significant risk factors.
8. Springer et al. (2010), USA Somali Bantu Refugees in SW Idaho: Assessment Using Participatory Research. Advances in Nursing Science 33(2), 170-181.	Assessing the health requirements of Somali Bantu refugees in S. W Idaho using a cultural and community assessment tool.	12 members of the Somali Bantu community, 5 health care workers and 5 volunteers.	Descriptive qualitative method using Community Based Participatory Research including both formal and informal interviews. Interviews analysed by searching for similarities and themes.	Health problems encountered included asthma, diabetes, high blood pressure, lack of vaccinations and obesity.	Findings suggested that this studied community had an increased risk for health disparities. Study highlights the necessity of increased screening, preventative care and community nursing in vulnerable populations.

9. Tobin et al. (2014), Ireland Irish midwives' experiences of providing maternity care to non-Irish women seeking asylum. International Journal of Women's Health 6, 159-169.	Gaining an understanding of how midwives can be better equipped and supported to provide more effective care for asylum seeking women.	10 midwives. Purposive sampling. 5 urban, 5 rural.	In-depth unstructured interviews. Content analysis	Five themes identified: barriers to communication, understanding cultural difference, challenges of caring for women who were non-booked in the system, the emotional cost of caring and structural barriers to effective care.	Researchers concluded that findings highlight the need for focus on supporting midwives to increase their cultural competence, better maternity services for immigrants and immediate effective policy changes.