



Providing Care for Refugee Patients: Challenges and Barriers

A literature review

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Bachelor Degree Thesis
Nursing
2018

DEGREE THESIS	
Arcada University of Applied Science	
Degree Programme:	Nursing
Identification number:	
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Commissioned by:	Arcada's Diversity & Inclusion project
Abstract:	
<p>The aim of this study is to review the literature regarding the challenges and barriers facing nurses when providing care for refugees arriving to new destination, and to review solutions and remedies to overcome these barriers. Before answering the research questions, this study will present statistical figures regarding refugees, and it will explore common health problems associated with refugees and asylum seekers. Additionally this study will also provide guidelines for nurses to provide culturally congruent care by using Leininger's Culture Care Diversity and Universality theory.</p> <p>This study is a qualitative literature review, academic articles were collected through academic database search engines like Cinahl (EBSCO), Pubmed, and Google scholar.</p> <p>The research questions of this study are 1) What types of challenges and barriers nurses face when providing care for refugees? 2) What challenges and barriers refugees face when receiving care from nurses in the host country? 3) How to overcome common barriers and challenges when providing care for refugees?</p> <p>The articles chosen for this study were analyzed by inductive qualitative method.</p> <p>The findings of this study identified language, cultural differences, referral process, lack of training and guidance, quality of care, health literacy, and lack of information, as major barriers for nurses and refugees during their healthcare encounters. Solutions and remedies suggested by both, care providers and refugees to overcome these barriers are the use of skillful interpreters, training and guidance, and connecting between services and sectors. This study also provided nurses with guidelines to use Leininger's three action modes in order to provide culturally competent care for refugees.</p>	
Keywords:	Refugees, asylum seekers, barriers, challenges, care provider, nurse, healthcare, culturally congruent care, solutions, Leininger theory
Number of pages:	44
Language:	English
Date of acceptance:	15.05.2018

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Foreword

I would like to take this opportunity to thank my supervising teacher Emilia Kielo for her guidance and support during the entire process of writing this paper. Also, I would like to thank my other teacher Pamela Gray for her additional help and support, and my fellow classmates at Arcada's nursing program.

1 INTRODUCTION

Across human history, unfortunate events like war, natural disaster, or economic crisis has caused people to migrate across borders seeking for safer and better environment. Most countries had shifted between different roles across their history from being a host for refugees, transition place for refugee, or a country where refugees left from.

The process of seeking refuge somewhere else includes moving to new places with different ways of living and with different cultural background, and different language. On the other hand, refugees travel with their own cultural and believe values and own native language. The nature of causes that cause refugees to leave their home countries and engage in a long exhausting and dangerous trip across borders, and the circumstances associated with their trip between multiple nations, expose such a population to several health problems.

Nurses are likely to be the first healthcare encounters for refugees when accessing healthcare service. While increasing the wellbeing and health for refugee are the goal for both parties at the healthcare transaction, the nurse and the refugee may carry different concepts of health and illness. This difference in perspectives affects the quality of healthcare provided for refugee and it adds to the vulnerability to this population group.

The several restless circumstances in many different geographical areas across the globe has caused a constant refugees' movement across countries, particularly to high income nations, and providing healthcare service for patients from refugee background happens on daily bases at healthcare facilities. However, the process is faced by many barriers and challenges for both, the nurse and the refugee patient. Barriers like language and cultural difference are among other issues which influence the health and the wellbeing of the refugee patient. Understanding the health background of refugees in addition to getting familiar with barriers and challenges that affect their health is important factor in providing high quality healthcare that lead to an increase in the wellbeing and the health welfare of refugees.

The purpose of this study is to provide nurses with knowledge about refugees' common health problems, and discuss barriers and challenges facing both the nurse and the refugee patient when providing care, also this study will discuss solutions suggested by healthcare professionals as well as refugees, in order to equip nurses with the proper tools to overcome these barriers and to provide high quality culturally competent care.

2 BACKGROUND

2.1 REFUGEE

What is a refugee? According to the UN 1951 Convention and Protocol Relating to the Status of Refugees, a refugee is an individual who “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it” (UNHCR The UN Refugee Agency, 2010).

On the other hand, according to the United Nations Educational, Scientific and Cultural Organization UNESCO, an asylum seeker is an individual “who move across borders in search of protection, but who may not fulfil the strict criteria laid down by the 1951 Convention. Asylum seeker describes someone who has applied for protection as a refugee and is awaiting the determination of his or her status. Refugee is the term used to describe a person who has already been granted protection. Asylum seekers can become refugees if the local immigration or refugee authority deems them as fitting the international definition of refugee” (UNESCO, 2017).

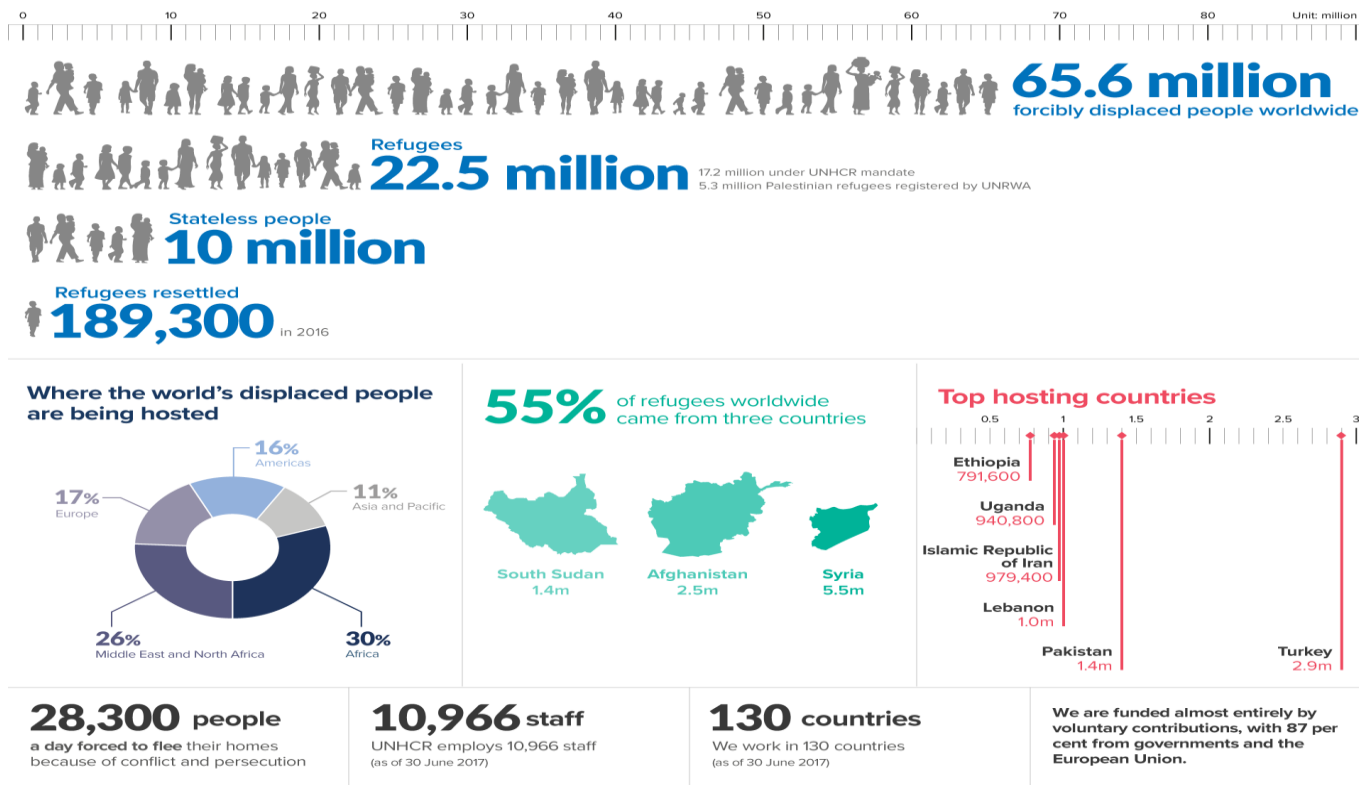
Though this definition may vary between countries due to different laws, in most countries the difference between a refugee and an asylum seeker is based on whether the individual applies for protection in the host country or if the protection is granted outside the host country (UNESCO, 2017). For the purpose of this paper which is concerned with issues regarding health care only, the legally distinct definitions for refugee and for asylum seeker will not be considered, and therefore both terms will be used synonymously unless otherwise stated.

2.2 Refugees and Healthcare

The rise of the so called Arab spring in 2010 (Academic, 2018), and the ongoing wars in middle east, as well as in other places around the globe, contributed to an unprecedented influx of refugees to new countries, and created the biggest refugee crisis inside Europe

since the Balkans war in the 1990's (Tourneur, et al., 2015). Escaping the ongoing civil war, Syrians were the largest group of refugees entering Europe 39% followed by Afghans 11%, and Eritreans 7%. Other refugees from Iraq, Nigeria, Pakistan, Somalia, and Sudan contributed to the migrant influx (Park, 2015).

According to the figures of UNCHR, we are witnessing the highest levels of displacement ever recorded in history (see Figure 1). 65.6 million forcibly displaced people around the world, among them almost 22.5 million refugees, over 50% of them are under 18 years old (UNCHR, 2017). In 2016, there were up to 189.300 refugees resettled around the globe (UNCHR, 2017). More than half of all the refugees worldwide came from three countries, South Sudan, Afghanistan and, Syria. Most of them are hosted in Asia and Africa (UNCHR, 2017). Western countries host more than third of all refugees and Europe alone host 17% (UNCHR, 2017). In 2016, Finland hosted 18,401 Refugees and 5,600 Asylum seekers after an unprecedented peak in 2015 when 24,366 asylum seekers applied for protection in the country. (UNHCR, 2015 / 2016)



Source: UNHCR / 19 June 2017 **UNHCR**
The UN Refugee Agency

Figure 1 (UNCHR, 2017)

While the health problems of refugees do not differ from the rest of the population, the long and stressful journey to the destination country, and the original state of the country of origin, contribute largely to the initiation or to the exacerbation of particular health problems (Tourneur, et al., 2015). Refugees are particularly prone to mental problems. A meta-analysis study from seven developed western countries suggested that about one in ten adult refugees settled in western countries had post-traumatic stress disorder, about one in twenty suffers from major depression and about one in twenty-five has generalized anxiety disorder, with the probability that these disorders overlap in many people. The study also suggested that refugees based in western countries could be about ten times more likely than the age-matched general American population to have post-traumatic stress disorder. (Fazel, et al., 2005)

While refugees are considered a vulnerable group in general, women and children in particular are considered very vulnerable and prone to health problems. (Tourneur, et al., 2015). Maternal, newborn and child health, sexual and reproductive health, and violence are common challenges faced by women. Whereas children are generally prone to gastrointestinal diseases, respiratory infections, and skin infections due to poor living circumstances during migration (WHO, 2018). Accidental injuries, hypothermia, burns, gastrointestinal illness, cardiovascular events, pregnancy and delivery related complications, diabetes and hypertension are all common health problems between refugees (WHO, 2018).

Contrary to common misconception there are no systematic links between migration and the importation of communicable diseases, however factors like war, conflict or economic crises, in addition to the long journeys during migration, contribute to high risk for both communicable and non-communicable diseases between refugees. Measles and food- and waterborne diseases are few examples. Other serious viruses and infections like Ebola, HIV, or Middle East respiratory syndrome are mostly imported by regular travelers, tourists or health care workers (WHO, 2018). However, during migration other health risks like psychosocial disorder, reproductive health problems, higher newborn mortality, drug abuse, nutrition disorders, alcoholism and exposure to violence, might expose refugees to non-communicable diseases like cardiovascular diseases, diabetes, cancer, and chronic lung diseases (WHO, 2018).

In addition to these health problems, other issues as well, affect the health and the well-being of refugees. People travel with different values, believe systems and different cultural background, they speak different language and their views on health care or care in general may be quite different from the views held by the residents of the host countries.

When refugees access health care at the new destination, nurses are usually their first encounters. The unprecedented large influx of refugees to Europe and the health problems associated with their journey as well as the variety of cultural backgrounds between refugees, all these issues created great challenges for nurses, and emphasized the importance of culturally congruent care and the need for culturally competent nurses.

2.3 Strengths and limitations of this study

There had been several studies regarding challenges and barriers facing refugees and care providers during their encounters through healthcare services. While many of these studies focused mainly on one party's perspective, refugees' or care providers', this study investigates both parties' views on the subject and provided two points of views regarding healthcare barriers. Additionally, this study investigates barriers and challenges inside the realm of mental healthcare, a realm which has been looked at separately with own barriers and challenges. Due to the high rate of mental healthcare problems between the refugees' populations, this study integrates the barriers facing care providers and refugees inside mental healthcare facilities to create general study taking into accounts most aspects of refugees' health.

On the other hand, this paper reviews findings based on data gathered from 14 different countries with different healthcare systems and policies regarding refugees' healthcare access and with different cultural backgrounds. This fact contributed to differences between experiences between refugees regarding certain issues, for example refugees' right to interpreting service or the transportation barriers. To some extent, this differentiation between experiences put some limit to come up with general data regarding all aspect of the barriers facing refugees and care providers in healthcare.

3 THEORETICAL FRAMEWORK

This study will be guided by Madeleine Leininger's theory of Culture Care Diversity and Universality (CCDU). In many of her work, Leininger warned about a situation when healthcare staff may impose their own values and beliefs on individual or group of patients while providing care. Leininger's CCDU model consider the nurse as a bridge between generic tradition practices and professional nursing. Patients are accompanied with nurses around the clock during their stay at healthcare units, which makes providing culturally congruent care a very important factor for good healthcare results. CCDU offers a structured approach to promote cultural competences among nurses (Sagar, 2011)

According to Leininger, nursing is a dynamic field of education and practice which considers multiple factors that affect the health and the wellbeing of the individual, like religion and culture. It is a unique profession to care for people in need around the globe. A profession which is influenced by many factors like ethnohistory, social structure, culture, and environment (Mcfarland & Wehbe-Alamah, 2006). The purpose of the culture care theory is to "discover, document, know, and explain the interdependence of care and culture phenomena with differences and similarities between and among cultures" (Mcfarland & Wehbe-Alamah, 2006). The goal of the theory however is to provide "culturally congruent, safe, and beneficial to people of diverse or similar cultures for their health, wellbeing, and healing, and to help people face disabilities and death" by using culture care research findings (Mcfarland & Wehbe-Alamah, 2006). She argued for a holistic care which is based on broad view that takes into account the sacredness and the uniqueness of humans and their culturally- based values in order to surpass the traditional nursing model which focus entirely on diseases, symptom relief, and pathological conditions (Mcfarland & Wehbe-Alamah, 2006).

The variety between refugees' backgrounds and values, as well as the cultural differences between the nurse and the refugee patient, made Leininger's Culture Care Diversity and Universality theory a proper tool to examine the issues investigated in this study.

3.1 Definitions of key concepts

Due to differences between definition of terms between different cultures, many integral constructs in the culture care theory are define and described to provide a guide for schoolers to avoid reflecting own interests or viewpoints in those definitions. Those integral constructs are (Leininger, 2006, pp. 12-16):

- *Care* according to Leininger are those sensitive, supportive, and enabling experiences or ideas towards others; on the other hand, *Caring* is the actions, attitudes, and practices to increase the wellbeing of others. Care is divided into two key concepts, generic (*emic*) care, and professional (*etic*) care. *Emic* care refers to the traditional or local knowledge and practices to improve the wellbeing or help with dying or other human conditions. *Etic* care refers to the knowledge and skills learned cognitively to healthcare staff through educational institutions in order to improve the health of others, to prevent illness, and to help with dying or other human conditions.
- *Culture* is the learned, shared, and transmitted values, beliefs, norms, and life-ways of a particular culture that guide thinking, decisions, and actions in patterned ways. Culture is what differ human from non-human, it is what guides peoples' behavior and actions within the group, and it is a way to predict, explain, and know the actions and behavioral patterns of group in different geographical areas.
- *Culturally congruent care* is the aim for the culture care theory. It refers to the culturally sensitive actions of trying to fit professional knowledge and skills into local values and believes of a certain culture.
- *Care diversity* refer to the individual differences with respect to culture care values and symbols or any other feature which fall into the category of providing care for people of a particular culture.

- *Culture care universality* refers to the shared features, values, patterns or symbols between different group of people that can be used as guidelines for caregivers to provide care that lead to healthy results.
- *Health* refers to a state of wellbeing that is culturally constituted, valued, and practiced, which enable members of the group to function in their daily life.
- *Ethnohistory* is a term derived from anthropology which refer to the previous experiences, knowledge, events, and facts of cultures, human beings, and groups, which occur over time and in particular context and serve as a guide to interpret the past and the present lifestyles about culture care influencers of health or the death of people.
- *Environmental context* refers to the magnitude of a particular event that give meaning to people interpretations and their social interactions within a cultural context.
- *Worldview* refers to the way people see and interpret their world in order to create a value stance about life or the world around them.

3.2 Action modes and theory assumptions

A major part of Leininger's CCDU is the three action modes that the theorist predicted to serve as a guide for nurses in order to provide culturally congruent care. These three modes which are based on research findings are essential for caring and are to be used with specific research care date discovered with the theory (Mcfarland & Wehbe-Alamah, 2006).

1. *Culture care preservation and/ or maintenance*: maintenance refer to those supportive professional acts or decisions which allows cultures to maintain care believes and values or to face permanent injuries and death

2. *Culture care accommodation and /or negotiation*: refer to those enabling creative care actions that help culture to adapt to others to achieve a culturally congruent care for health, or to deal with illness or death.
3. *culture care repatterning and /or restructuring*: refer to those supportive professional actions and mutual decisions that would allow people to modify or reorganize their ways of living for health outcomes and to increase their wellbeing.

These actions modes led the way to form major theoretical assumptive premises for the theory that can be applied in both western and non-western culture, these premises are (Leininger, 2006, pp. 18-19):

- Care is the essence, distinct, and unifying focus of nursing.
- Humanistic and scientific care is an integral part for wellbeing, health, survival, human growth, and to face death and disabilities.
- Culture care is a combination of two major constructs that guide the researcher to discover, explain, and account for health, wellbeing, care expressions, and other human conditions.
- Culture care expressions, meanings, patterns, processes, and structural forms are various, but some commonalities exist between cultures.
- Culture care values, beliefs, and practices are influenced by and rooted in the worldview, social structure factors, and the ethnohistorical and environmental contexts.
- Every culture has generic (emic) and professional (etic) care to be discovered and used for culturally congruent care practices.
- Culturally congruent care occurs when culture care, values, beliefs, expressions, and patterns are well known and used appropriately, sensitively, and meaningfully with people of different or similar cultures.
- The three action modes of care offer new, creative and different way to care for people of different cultures.
- Qualitative research paradigmatic methods offer important means to discover embedded, epistemic, and ontological culture care knowledge and practices.

- Transcultural nursing is a method made of the knowledge and practice to reach and provide culturally congruent care.

3.3 Social structure factors and sunrays enabler

Care expressions and meanings are influenced by many social structure factors that need to be understood due to their direct and in direct impact on the health and wellbeing (see Figure 2). Social structure includes religion and philosophy of life, kinship, politics and legal issues; educations; economics; technology; and cultural beliefs and values with gender and class differences. These factors create sunrays which influence individuals, and groups in health and illness and it serve as facilitating way for caring different group in various health systems (Mcfarland & Wehbe-Alamah, 2006)

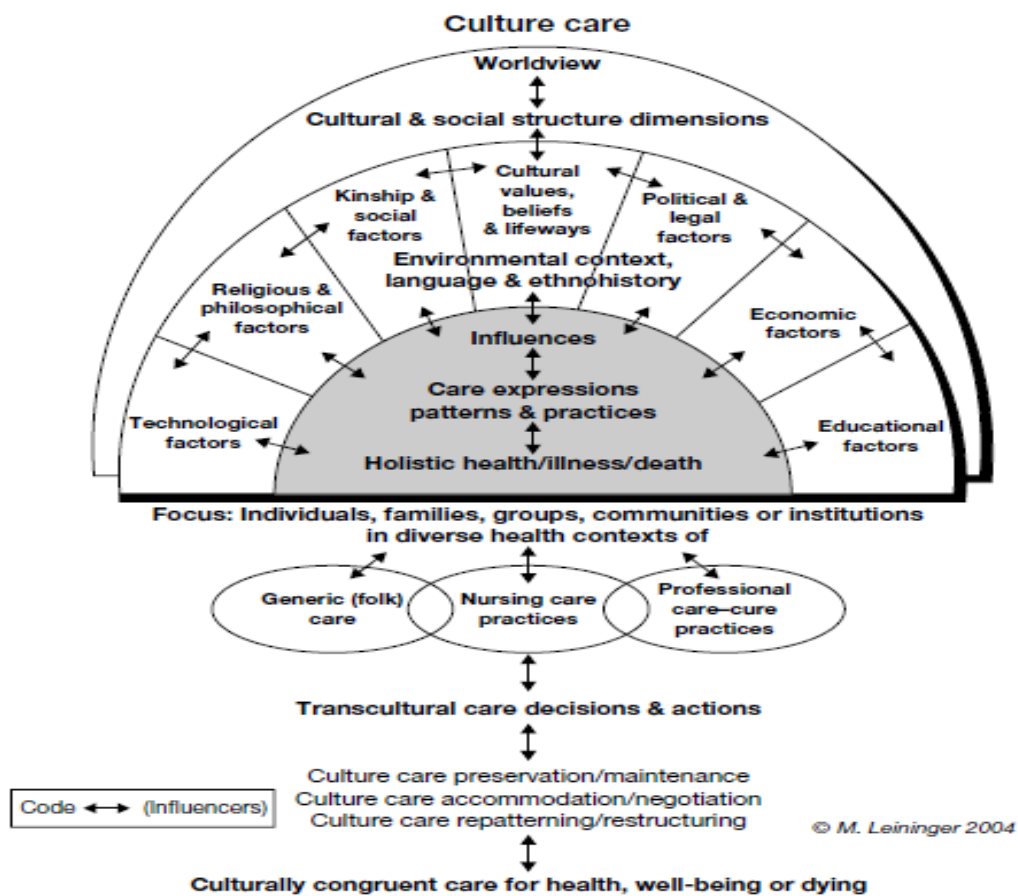


Figure 2 (Sagar, 2011)

4 AIM AND RESEARCH QUESTIONS

The aim of this study is to review the literature regarding the challenges and barriers facing nurses when providing care for refugees arriving to new destination. Viewed from both perspectives, the care providers, and the refugees, this study will discuss suggested solutions and remedies to overcome these barriers. This study will also provide guidelines for nurses to provide culturally congruent care by using Leininger's Culture Care Diversity and Universality theory.

The research questions of this study are:

1. What types of challenges and barriers nurses face when providing care to refugees.
2. What challenges and barriers refugees face when receiving care from nurses in the host country.
3. How to overcome common barriers and challenges when providing care for refugees.

5 METHODOLOGY

This study is conducted as a qualitative literature review. Academic articles were collected through academic database search engines like Cinahl (EBSCO), Pubmed, and Google scholar. Before collecting the data, a criterion was set for inclusion and exclusion of articles to be reviewed for this study (see Figure 3).

For Cinahl database the search words used were: "*Refuge experience and health care*" (n=25) "*Refugee health and challenges barriers or difficulties*" (n=79). For Pubmed the search words were: "*Refugee and challenges*" (n=215), "*Refugee experience and healthcare*" (n=104), and "*healthcare barriers and refugee*" (n=107). For google schoolers the search words used "*barriers to refugee healthcare*"

The initial time frame which has been used in the searching process was sat for 10 years 2018-2008, however due to the low amounts of articles found which can be used in this study, additional two years has been added, expanding the time frame from 2006 till 2018. Additionally, the articles which have been chosen for this study are focused on refugees and asylum seekers only, even though refugees fits into the United Nations

definition of immigrant (UN, 2018) “international migrant is someone who changes his or her country of usual residence, irrespective of the reason for migration or legal status”, studies about immigrants in general have been excluded due the fact that the term include many different groups with different healthcare, and it include individuals who moved to a new country under different circumstances than refugees.

Professions included in this study include, doctors, nurses, physicians, social workers, and refugee support workers. Studies related exclusively for nursing were not available.

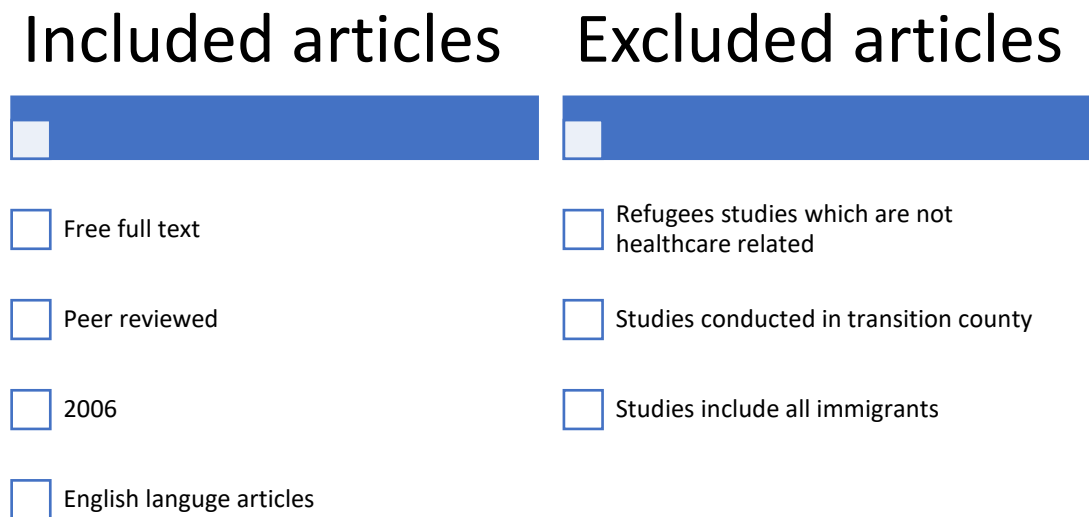


Figure 3

Eight articles were picked for this study after browsing through the title and abstracts of 526 articles on EBSCO and Pubmed. The remaining two articles were picked via Google scholar. Due to the large number of the search results generated by Google Scholar, only 20 articles were browsed for inclusion (see Figure 4).

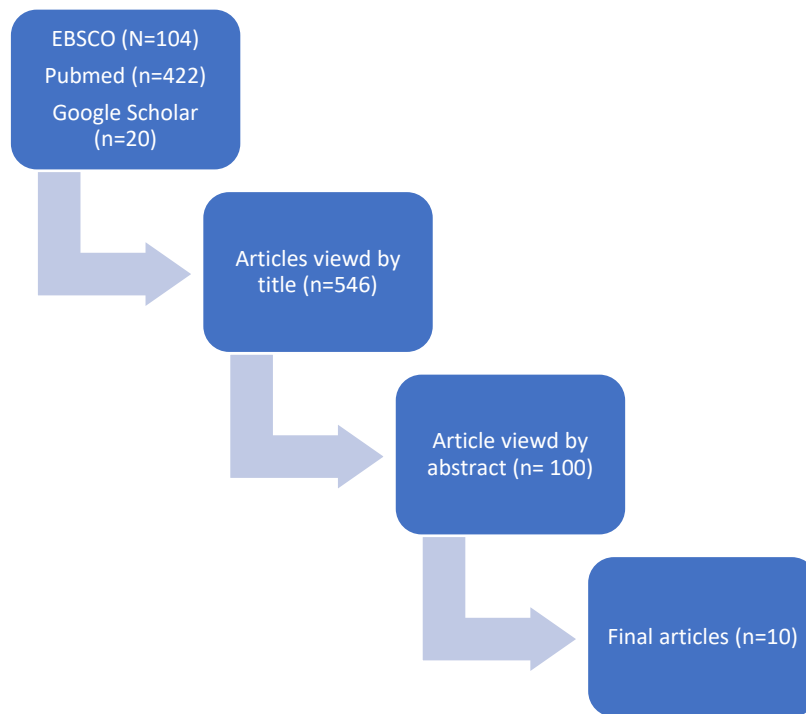


Figure 4

Three of the chosen studies were about primary care, two were about mental care, and 5 were about healthcare in general (see Table 1)

<i>Article</i>	<i>Author</i>	<i>Year</i>	<i>Method</i>	<i>Country of study</i>	<i>Participants</i>	<i>Type of healthcare</i>	<i>Aim of Study</i>
Barriers to access to health care for newly resettled sub-Saharan refugees in Australia	Mohamud Sheikh-Mohammed, C Raina MacIntyre, Nicholas J Wood, Julie Leask, David Isaacs	2006	Descriptive epidemiological study and survey	Australia	34 Parents of a possible 35 sub-Saharan African families who had lived in Australia for less than 5	General healthcare	To determine barriers that affect access to health care for refugees from sub-Saharan Africa resettled in Sydney

Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries	Luke Robertshaw, Surindar Dhesi, Laura L Jones	2017	Systematic review and qualitative thematic synthesis. Methods Synthesis	UK, USA, Australia, Canada, Ireland, Sweden, Switzerland, Netherlands, Denmark, New Zealand	Twenty-six articles reporting on 21 studies and involving 357 participants (general practitioners, nurses, pharmacists and midwives working in primary healthcare settings)	Primary healthcare	To thematically synthesize primary qualitative studies that explore challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries.
‘Excuse me, do any of you ladies speak English?’ Perspectives of refugee women living in South Australia: barriers to accessing primary health care and achieving the Quality	Alice Clark, Andrew Gilbert, Deepa Rao and Lorraine Kerr	2014	Focus group discussion	Australia	Thirty-six refugee women from six countries	Primary healthcare	to identify the barriers to accessing primary health care services and explore medicine-related issues as experienced by refugee women in South Australia

Use of Medicines							
Exploring Healthcare Perspectives of Burmese Chin Refugees	Megan S. McHenry, Rachel Umoren, Avika Dixit, Rachel Holliday, Debra Litzelman,	2016	Cross-sectional household survey and focus group discussions	USA	Six focus group of Burmese refugees living in Indianapolis. Average group had 6 (range 2-10) participants	General healthcare	<i>to understand the Burmese Chin refugees' experiences with and perspectives on the United States healthcare system</i>
Healthcare Barriers of Refugees Post-resettlement	Meghan D. Morris, Steve T. Popper, Timothy C. Rodwell, Stephanie K. Brodine, Kimberly C. Brouwer	2009	Guided in-depth interviews	USA	40 informants in San Diego county (health care practitioners, employees of refugee serving organizations, and recent refugee arrivals)	General healthcare	to explore health care access issues of refugees after governmental assistance has ended.
How do general practitioners experience providing care to refugees with mental	Natasja Koitzsch Jensen, Marie Norredam, Stefan Priebe, Allan Krasnik	2013	Semi-structured interviews	Denmark	Nine general practitioners, three emergency room physicians, and three managers of psychiatric residential	Mental healthcare	To investigate how general practitioners experience providing care to refugees with mental health

health problems?					units.		problems
Improving delivery of primary care for vulnerable migrants	Kevin Pottie, Ricardo Batista, Maureen Mayhew, Lorena Mota, Karen Grant	2014	Modified Delphi consensus process	Canada	Forty-one primary care practitioners, including family physicians and nurse practitioners, who provided care for migrant populations	Primary healthcare	To identify and prioritize innovative strategies to address the health concerns of vulnerable migrant populations
Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: addressing the barriers	Miriam Posselt, Karalyn McDonald, Nicholas Procter, Charlotte de Crespigny, Cherrie Galletly	2017	Semi-structured interviews and online survey	Australia	Fifteen refugees aged between 12 and 25 years and Thirty service providers from government and non-government MH, AOD, refugee support service, qualified social workers, psychologists, and mental health nurses/nurse practitioners	Mental healthcare	To investigate the barriers and facilitators to culturally responsive comorbidity care for these youths and whether the MH and AOD services were equipped to provide such support
Refugee experiences	I-Hao Cheng, Ann	2015	Literature review	USA, Canada, England,	Twenty-three papers includ-	General healthcare	To describe and analyze

of general practice in countries of resettlement:	Drillich and Peter Schattner			Scotland, Ireland, Netherlands, Norway, Sweden, Finland, Switzerland, New Zealand, Australia	ed in the review, of which thirteen focused on refugees, three focused on asylum seekers and seven focused on both		the literature on the experiences of refugees and asylum seekers using general practice services in countries of resettlement.
Refugees' experiences of healthcare in the host country: a scoping review	Elisabeth Mangrio, Katarina Sjögren Forss	2017	Scoping review	USA, UK, Canada, Australia, Netherlands, Sweden, Greece, Scotland, Iran	Twenty -two studies focused on refugee or asylum seekers healthcare experience in nine different countries.	General healthcare	To compile research about the experiences that refugees have with the healthcare system in their host countries

Table 1

5.1 Ethical considerations

Ethics set the norms and standards for behavior that distinguish between right and wrong, and it help determine between what is acceptable and what is not (Anon., 2018). One fundamental part of the research process is ethical considerations, it is very important part of any research process due to its ability to prevent against the fabrication or falsifying of data and therefore promote the main goal of the research, the pursuit of knowledge and truth. In addition to that, ethical behavior encourages environment of trust, accountability, and mutual respect among researchers during collaborative work. Data sharing, co-authorship, copyright guidelines, and confidentiality are few example of issues where ethical behavior is of extreme importance.

Following ethical guidelines when conducting a research is vital for the public to support and believe the research, and it effects the integrity of the research project and can be a decisive factor in whether or not the project will receive funding (Anon., 2018). The International Center for Nursing Ethics (ICNE) offered five guiding principles for designing and reviewing research (ICNE, 2003): (1) Respect for persons; (2) beneficence; (3) justice; (4) respect for community; and (5) contextual caring. As for this research, the writer who is a nursing student at Arcada, followed and adhered to the guiding principles of the ICNE as well as the guidelines required by Arcada University of Applied Sciences. The topic of this research has been discussed with the supervisor and agreed by Arcada. The author has been careful to avoid any plagiarism or to use any false information during this study, also the writer strived to write this paper in a neutral manner and to refrain from being biased in selecting reference materials for this study. The quotation and referencing guidelines stated by Arcada thesis guide are strictly followed during this study. Depending on their availability, some references were cited based on their original source, while others were used based on secondary source.

5.2 Content analysis

Inductive approach is the recommended analysis when a knowledge about a subject is not enough or fragmented. Inductive data analysis moves from the specific to general, where a general statement made from particular instances (Elo & Kyngäs, 2007). The three main stages of analysis were used according to Elo & Kyngäs (2007):

1. **Preparation:** Selecting the unit or the theme of analysis and making sense of data collected. The unit of analysis for this study is the research question.
2. **Organizing:** Divided into three stages:
 - a. *Open coding* is the process of creating descriptive headings of the data being analyzed and write them down on a coding sheet.
 - b. *Creating categories* is the stage where free categories are created and grouped under higher order headings. The new categories are formulated on the basis of belonging to a particular group.

- c. *Abstraction* is the stage when a general description of the research subject is formulated by through generating categories.
3. **Reporting:** Is the stage where the result and the finding of the analysis process are reported. (see Figure 5)

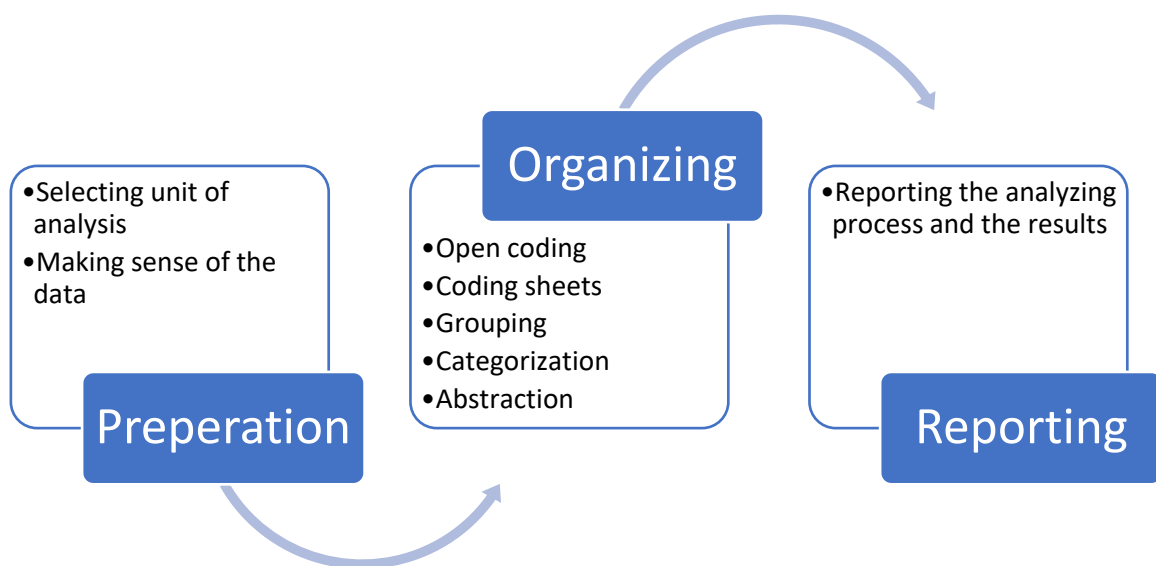


Figure 5 (Elo & Kyngäs, 2007)

The inductive content analysis for this study resulted in subthemes for each of the research question (see Figure 6)

The subthemes for the first research question based on data taken from healthcare staff (General practitioners, nurses, pharmacists, midwives, psychologists, and ER physicians), social workers, and refugee support workers are the following:

- 1) Language / communication.
- 2) Culture differences.

3) Referral process.

The subthemes of the second research question based on data taken from refugees from different nationalities and different ethnicities are the following:

1) Quality of care.

2) Health literacy.

3) Lack of information.

4) Language and communication.

5) Referral process.

6) Cultural differences.

The subthemes of the third and last research questions based on data taken from healthcare staff, social workers, refugee support workers, and refugees are the following:

1) Training and guidance.

2) Interpreting services

3) Connecting with other service.

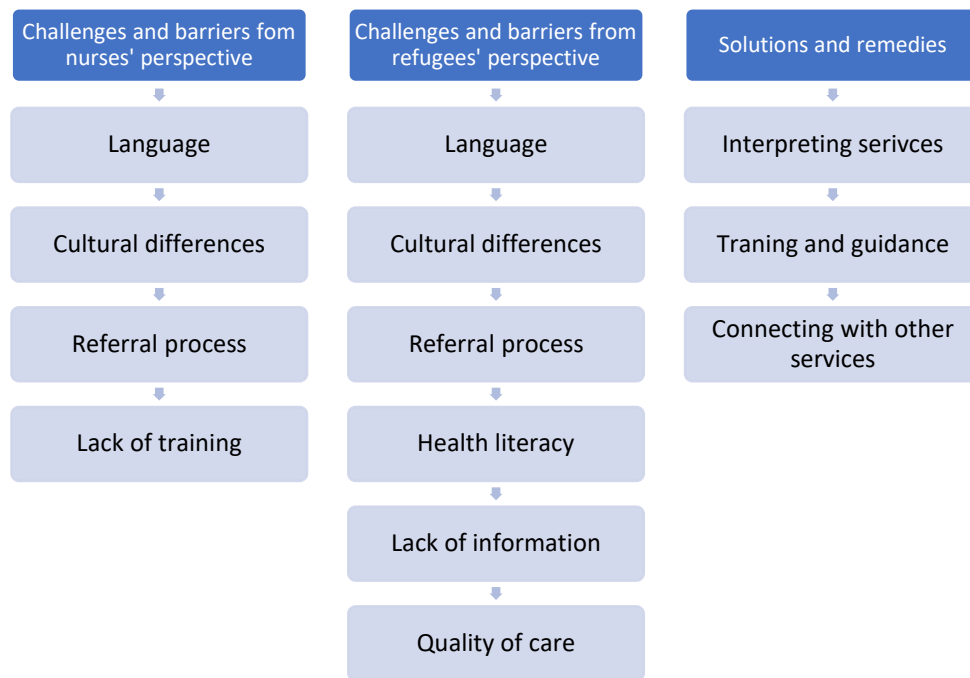


Figure 6

6 FINDINGS

6.1 Challenges and barriers faced by nurses when providing care for refugees

Three main barriers were identified by care providers, language, cultural differences, referral process, and lack of training and guidance. (see Figure 7) Care providers include nurses, general practitioners, ER physicians, psychologist, social workers, and refugee support workers.

Language barriers: Language is considered as major challenge for both, the nurses and the refugees, during their healthcare encounter. Interpreters are provided most of the time, and in case of unavailability of interpreters, some family members or a friend of the refugee patient took the role of the interpreter. However, problem raised with issue regarding funding for interpreters or with the lack of interpreters with professional medical terminology skills. (Robertshaw, et al., 2017), (Posselt, et al., 2017), and (Koitzsch, et al., 2013).

Cultural understanding: Culture differences considered as another major barrier for nurses during their healthcare encounter with refugee patients. Refugees and nurses had different understanding of the health/illness concepts, and refugees had high expecta-

tions from the care providers and from the treatment as well. (Robertshaw, et al., 2017), (Posselt, et al., 2017), and (Koitzsch, et al., 2013)

Referral process: Referral process is another challenge for the nurses during their service to refugee (Robertshaw, et al., 2017), (Posselt, et al., 2017), (Koitzsch, et al., 2013). In many cases refugees are referred to other services because some services believed they are not suitable to provide care for such a client group. Referral also interrupt the continuity of care for refugees.

Training and guidance: Lack of training for nurses to deal with refugees is another challenge when providing care for this group. This affected the quality of care the refugees received during their visit to healthcare facilities. (Robertshaw, et al., 2017), (Posselt, et al., 2017), (Koitzsch, et al., 2013).

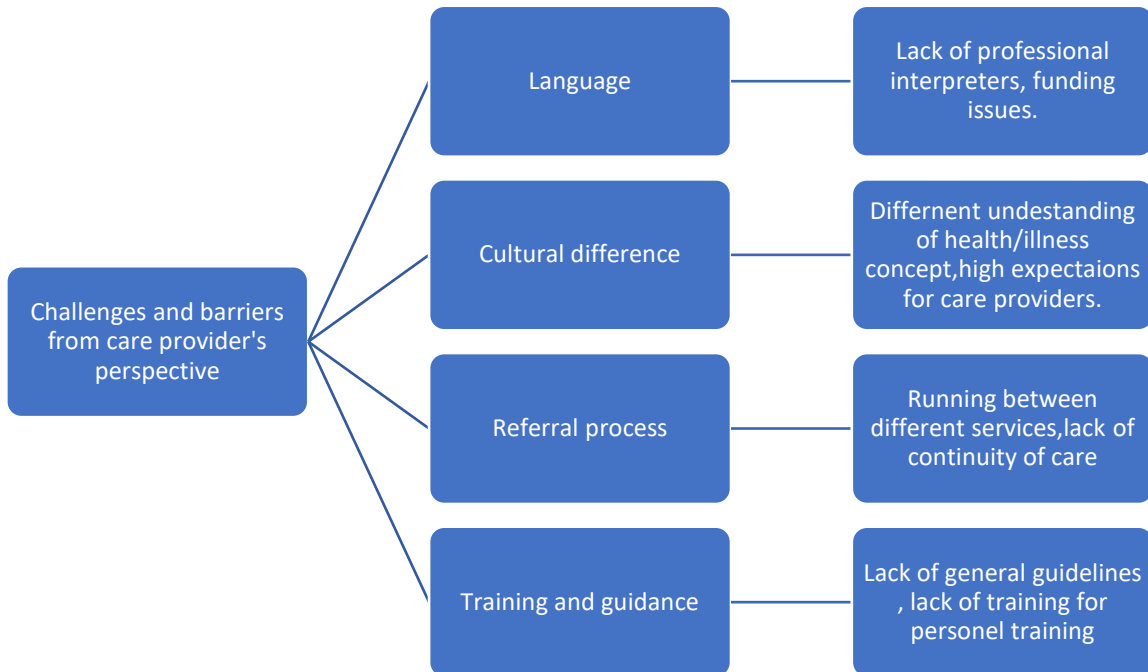


Figure 7

6.2 Challenges and barriers faced by refugee patient when receiving care

Six healthcare barriers are identified by refugees, quality of care, low literacy, language, lack of information, cultural differences, and referral process (see Figure 8)

Quality of care: Particularly the relationship with the care provider, is considered a common barrier between refugees when receiving care. (Mangrio & Fross, 2017), (Mchenry, et al., 2016), (Cheng, et al., 2015). Refugees lacked psychological support and had a trust issues when encountering a nurse or care provider, also they suffered from stereotyping or stigma on behalf of the care providers.

Low literacy: Low literacy was a common issue with refugees (Mangrio & Fross, 2017), (Sheikh-Mohammed, et al., 2006), (Cheng, et al., 2015), (Clark, et al., 2014), (Morris, et al., 2009). Problems raised when refugees didn't understand the reasons for examination or didn't understand the illness, while some refugees were illiterate in their own language which made understanding treatments and illness more difficult.

Lack of information: Information regarding patient's right and their access to health care service were considered another barrier for refugees. Refugees were not familiar with the health care system and had troubles with booking an appointment, accessing health care out of hours, and were confused about who's responsible for providing interpreter (Mangrio & Fross, 2017), (Cheng, et al., 2015), (Clark, et al., 2014).

Language: Several articles (Mangrio & Fross, 2017), (Sheikh-Mohammed, et al., 2006), (Mchenry, et al., 2016), (Cheng, et al., 2015), (Clark, et al., 2014), and (Morris, et al., 2009) considered language as the most common barriers to refugees. Language barrier was present at every stage during care, starting from booking an appointment to taking medication. When an interpreter was unavailable, refugees depended on family members or friends who lacked professional skills, and when interpreter were provided refugees were facing a problem with confidentiality, and with the quality of translation.

Referral process: The long and sometimes complicated process of referral to other specialist was another barrier for refugees. The main problems arose from referral were the lack of continuity of care, and the long waiting time for appointments (Mangrio &

Fross, 2017), (Sheikh-Mohammed, et al., 2006) (Cheng, et al., 2015) (Morris, et al., 2009).

Cultural differences: (Mangrio & Fross, 2017) (Sheikh-Mohammed, et al., 2006), (Mchenry, et al., 2016), (Cheng, et al., 2015), (Clark, et al., 2014), (Morris, et al., 2009) explored the cultural differences between the nurse and the refugee. Pre-existing experiences of healthcare services created a major challenge for refugees when they received healthcare. Refugees had high expectations of healthcare quality in the host country and they expected certain treatment patterns from the nurses or from the care providers. Refugees had difficulties understanding the healthcare systems in the host countries, and they were afraid of stigma in case they had infectious diseases or mental illness. Contrary to the common believe by nurses and care providers, refugees did not consider traditional medicine as replacement for western medicine. Traditional medicine was strongly practiced within the community, but it was not considered barrier when receiving healthcare.

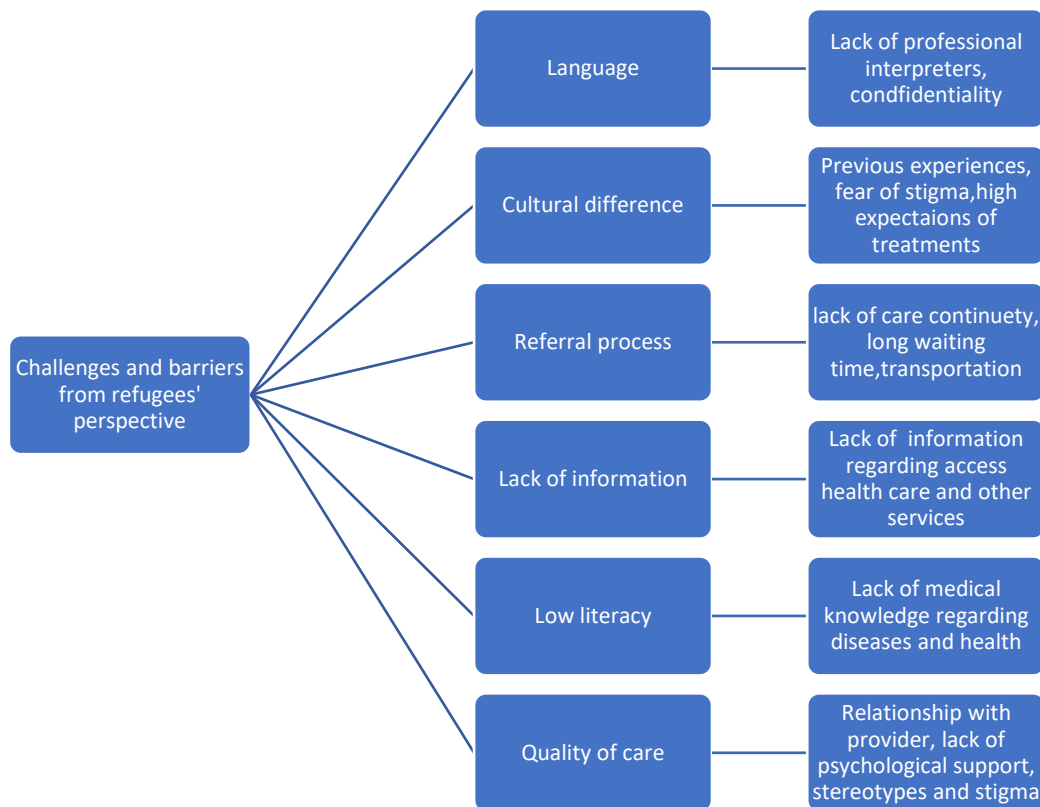


Figure 8

6.3 Solutions and methods to overcome barriers suggested by both, care providers and refugees

Both care providers and refugees suggested solutions and remedies to overcome the barriers during healthcare encounter. These solutions are skillful interpreting services, training and guidance, and connecting with other services (see Figure 9)

Interpreting services: The use of professionally trained interpreters is considered as major solution to language barriers. Visual aids, video conferences can also be used in case the physical presence for interpreters is not possible. (Robertshaw, et al., 2017), (Posselt, et al., 2017), (Mangrio & Fross, 2017), (Sheikh-Mohammed, et al., 2006), (Mchenry, et al., 2016).

Training and Guidance: (Robertshaw, et al., 2017), (Koitzsch, et al., 2013), (Posselt, et al., 2017), (Clark, et al., 2014), (Morris, et al., 2009), and (Pottie, et al., 2014) emphasized on the importance of training for nurses and care providers to provide culturally competent care, and to provide nurses with information about the culture of refugee and also about the common health problems associated with refugees. Refugees on the other hand need to be oriented towards the healthcare system in the host country as well as they need to be provided with health literacy courses.

Connecting with other service: This includes establishing referral pathways, as well as providing a national database which can provide health background information about refugees. The studies also showed that collaboration with refugee community is vital step in this process. Providing holistic care would solve the problems of fragmented services and will contribute to build trusting relationship between the care providers and the refugees (Robertshaw, et al., 2017), (Posselt, et al., 2017), (Koitzsch, et al., 2013), (Mangrio & Fross, 2017), (Mchenry, et al., 2016).

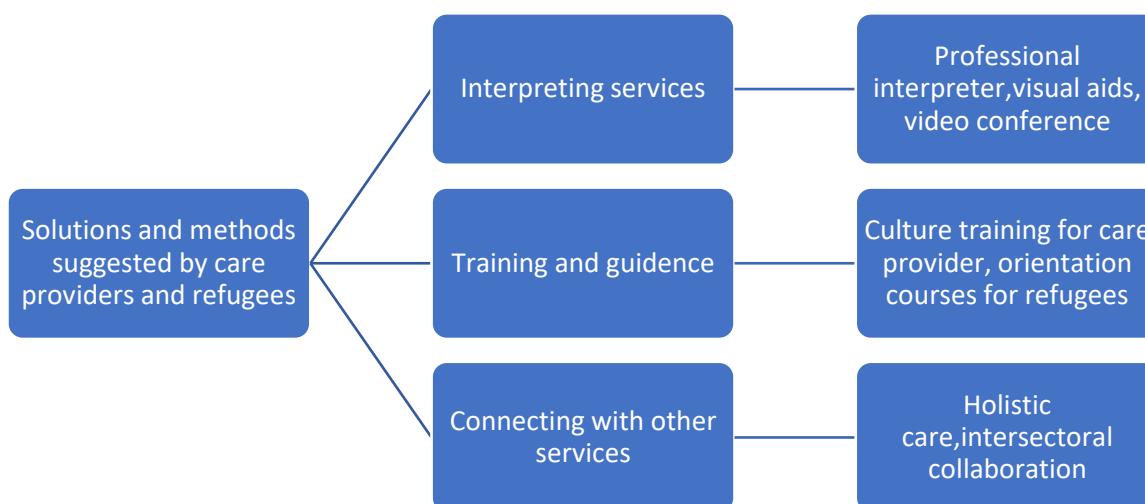


Figure 9

7 DISCUSSION

7.1 Challenges and barriers from care provider's perspective

The care provider term includes multiple different professions including nurses. However, taking Leininger's definition of care and caring 3.1, the essence of each of this profession is the same, and that is care. Social workers and refugee support workers are professional employees whom main task is to provide care for various vulnerable groups including refugees and asylum seekers. While the type of care is different than the care provided by healthcare staff, there are some similarities between the issues raised when caring for refugees, which explained the reasons why they have been included together in the same groups in various studies concerning refugees. In addition to that, there are constant collaborations between healthcare services and social services, and occasionally with refugee support groups, therefore, the care providers perspective mentioned in this study can also be generalized to be considered as nurses' perspective as well.

Three articles provided a look at the challenges and barriers faced by care providers when providing care for refugees (Robertshaw, et al., 2017), (Posselt, et al., 2017), and (Koitzsch, et al., 2013) . According to these three articles, challenges were language, cultural differences, lack of trainings, and referral process.

Language is considered as the biggest barrier for both refugees and care providers when providing care. The use of interpreters did not always solve the problem, finding interpreters with medical terminology skills is not an easy task and in many cases family member or a friend who lack professional skills stepped in for the role of interpreter. Funding for interpretation service was another issue as professional interpreting service is expensive and some healthcare facilities chose to skip the service to save some costs. Telephone interpreting is considered somehow impersonal, and technological failure might interrupt the video conference interpretations. Sometimes the language barrier stood in the way of refugees to access other services like conversational therapy or referring to a psychologist.

Cultural differences between the nurse and the refugee were another major challenge for the nurse. Some nurses argued that the western therapeutic approach may not be suited for refugee. Refugee had different understanding of the concepts of health, disease, and treatment and they had large expectations on the role of the nurse, which exceeded their role as a care provider. Caring for refugees with mental problem or with substance abuse was particularly challenging process. Nurses implied that refugees didn't understand the connection between psychological symptoms and physical symptoms, and the role of family in the treatment process was valued differently by refugees. Additionally, assumptions and stereotyping of certain groups' cultural backgrounds by the nurse contributed to assume the absence of substance abuse between some refugee communities.

Nurses complained of lack of training and the absence of clear guidelines when caring for refugees or asylum seekers. The absence of training and guidance contributed to lack of professional support for traumatized refugees and in some cases, it led to let some symptoms which caused by traumatizing experiences to pass unnoticed by the care provider.

Long referral pathways were another problem from the care provider perspective, refugees were victims to an ongoing referral process between services, and at some level, some services were not available for this particular group.

Learning new language is no easy task, even if people can sometime manage by a common language like English for example, medical terms can still sound unfamiliar. Interpreters are used in many areas, at police station, airports, or at the social services how-

ever, understanding medical terms is another story for some medical term can be difficult to understand even in native languages.

Many of today's modern society are multi-cultured, particularly western societies, however the situation in small cities can be different from big ones. People can still be unfamiliar with traditional practices and believes among other cultures, and the way certain foreign groups perceive health and illness can still be unfamiliar to people living in big multicultural urban areas. Nurses, doctors, and all care providers are part of the society and the city they live in, and they may share this unfamiliarity of the way other groups perceive health. Because of that, misunderstanding and confusion is not uncommon when foreigner access health care facilities at a new country. Even though training can notably reduce or eliminate such misunderstanding, finding the fund for such training projects can still be quite challenging.

7.2 Challenges and barriers from refugees' perspective

(Mangrio & Fross, 2017), (Sheikh-Mohammed, et al., 2006), (Mchenry, et al., 2016), (Cheng, et al., 2015), (Clark, et al., 2014), and (Morris, et al., 2009) provided answer to the second question regarding the challenges and barriers faced by refugees when receiving care. Those challenges are language, cultural differences, referral process, lack of information, quality of care, and low literacy level.

Language barrier is a problem for refugees on every level, starting from booking an appointment to using medicine. While interpreters were used in most cases, problems encounters refugees when using interpreters because of issues like different dialect within the language, medical terminology skills, and disclose of personal information to a third party who happened to be in many cases a member of the same community of the refugees.

Refugee healthcare experiences is mostly shaped and formed by previous healthcare experiences in the home country or by their experiences in the country of transition. These experiences contributed to form certain expectations on the role of the nurse and on the treatment process in general. Previous experiences and cultural differences affected mental care in particular due the fact that refugees were reluctant to admit their

needs for mental care or to engage their family in the treatment process because of their fear of stigma inside their community, or because of their fear of being deported or losing their asylum right. In some instances, the gender of the nurse or the interpreters facilitated the caring process by allowing refugee patients to be more open about their health issues to people from the same gender. Another culture difference between nurses or care providers and refugees, was the role of traditional medicine within the refugee community. While some care providers considered the role of traditional medicine a barrier when providing care for refugee patients, refugees on the other hand did not consider it a replacement for western medicine, despite being strongly present within their community.

Relationship with the care provider was of particular importance to refugee patients, some refugees feel victims to stereotyping or discrimination by the nurse while other refugees were disappointed by rushed and busy nurses. Refugees preferred open and sympathetic nurse who were interested in the refugees' past and who were sensitive to their culture values and beliefs. This was particularly important for refugees in order for them to open up about their traumatic experiences from the past.

Many refugees suffered from a low literacy level which made it difficult for them to understand diagnosis, physical examination, or to see any use of the treatments. This contributed to poor understanding of health and symptoms of diseases by the refugee population.

Refugee patients were unfamiliar with the healthcare system in the host country. Information about how to book for an appointment, availability of other services, or information regarding the responsibility of providing an interpreter were not available. Many refugees considered the healthcare system in the host country complicated and not easy to understand. Lack of information was a strong barrier when it comes to the insurance services and expenses associated with it. Additionally, refugees were not informed about their rights and entitlements concerning healthcare access.

The ongoing referral process to other services contributed to long waiting time for new appointment, and to lack of continuity of care. Refugees considered referring to other services a complicated process and new appointment took from days to months to be granted. The fragmented service was particularly frustrating for refugees as many experi-

enced problems in transportation to clinics. The referral also led refugee patients to see a different doctor or nurse every time.

Financial hardship was also a dominant barrier for some refugee, specifically the financial burden of insurance fees, co-payments, and out of coverage prescriptions.

Refugees are vulnerable group who are victims of displacement due war or restless state. Leaving the familiar home and moving to a new unfamiliar destination can be quite hard process, particularly for the elderly. Learning new language and getting familiar with new culture is not easy especially if people were illiterate in their own language. While they can still manage with daily activities, problems arise when accessing healthcare services, for a misunderstand can be life threatening. In addition to that, prejudice and stereotyping is not uncommon phenomena at any society, feeling of stigma and fear of deportation is part of the lives of many refugees and it affect some aspects of the quality of the healthcare they receive. Trusting a nurse or an interpreter is not as easy as it may sound for some refugee have had traumatizing experience in their home country or on the way to the host country.

In addition to new culture, getting familiar with new healthcare system or any other system at a new country is difficult not only for refugees but for immigrants in general. Systems can be complicated, intertwined with other sectors, and it makes fully understand the healthcare access procedures quite an exhausting task.

7.3 Solutions and remedies suggested by care providers and refugees

Refugees as well as care providers suggested solutions and remedies to overcome the barriers and the challenges both parties are facing during the caring process. These solutions include the use of skillful interpreters, providing training and guidance for both care providers as well as for refugees, and connecting between services and sectors.

The use of interpreting service may not be enough to resolve the language barrier, however (Robertshaw, et al., 2017), (Koitzsch, et al., 2013), (Clark, et al., 2014), (Morris, et al., 2009), and (Pottie, et al., 2014) emphasized the importance of increasing the quality of the interpretation for clear communication between the refugees and the care provid-

ers. Visual aids, and video conference can be used in case the physical presence of interpreter is not possible. Interpreting services are encouraged to include consumer medicine information.

(Robertshaw, et al., 2017), (Koitzsch, et al., 2013), (Posselt, et al., 2017), (Clark, et al., 2014), (Morris, et al., 2009), and (Pottie, et al., 2014) concluded that training and guidance to nurses on how to care for patients from refugee background is considered as a major facilitator to the caring process. Care provider need to be informed about common health problem associated with refugees, in addition to that, they need to be familiar with the cultural background of refugee, and general guidelines are required for care providers in order for them to be able to provide culturally competent care for this vulnerable group. On the other hand, orientation about the health care service as well as the use of medicine, in addition to providing refugees with general information regarding healthcare are important measures to solve the health literacy issues and the lack of information between refugees.

(Robertshaw, et al., 2017), (Koitzsch, et al., 2013), (Posselt, et al., 2017), (Clark, et al., 2014), and (Pottie, et al., 2014) suggested that connecting between sectors and an exchange of information between different healthcare sectors, civil society organizations, and refugees' communities are important measures to facilitate the referral process between sectors, and a step towards increasing the flow of information between institutions in order to make data about refugees available between sectors, and to provide holistic care for such a vulnerable group. The studies also suggested flexibility and adaptations regarding the locations and the times of healthcare appointments for refugees.

7.4 Cultural competent care

Leininger considered care as the essence, distinct, and unifying focus of nursing. Taking Leininger theory into account nurses will be guided to overcome the cultural barriers and to reach the goal of the theory, which is providing culturally congruent, safe, and beneficial care to people of diverse or similar cultures, for their health, wellbeing, and healing, and to help people face disabilities and death.

Providing culturally congruent care is major facilitator to the barriers in caring for refugee group. Refugees come from completely different background than nurses, they carry different world view, different believe system, and their concept of health and care

are shaped and influence by different social structures. This difference in understanding created a major challenge for both nurses and refugees during the caring process and it affected the quality of care received by refugees.

The findings of this study imply a need for cultural training for nurses, a training which takes into account the social structures of the refugee's previous environment, and also to provide the nurse with knowledge about the emic health beliefs and practices within the refugee community. This study also implies an information gap between nurses regarding the emic practices and values inside the refugee community.

While nurses believed that some of the emic practices and beliefs stand in the way of treatment, refugees ranked professional practice with high regard and didn't consider emic health practices as a replacement for professional interventions.

Culturally competent nurses allowed refugee patients to be more open about their health problems and they felt valued and respected and treated as a unique individual with own needs, and it eased the flow of communication between the refugee patient and the nurse. Cultural competent care will allow the nurse to be as a bridge between generic practices and emic practices by guiding the nurse to use the three action modes suggested by Leininger.

The literature reviewed in this study suggests few recommendations and guidelines for nurses to help them go through barriers when providing care for refugee patient. These recommendation measures will be viewed based on Leininger's Culture Universality Theory.

Empathy is a fundamental part of the caring process. Empathy defined as "The ability to imagine oneself in another's place and understand the other's feelings, desires, ideas, and actions" (ACADEMIC, 2018) Empathy will help to guide nurses to understand the worldview of the refugee patient and to be aware of their cultural and social contexts. This require nurses to be aware of many aspects of the refugees' life. As a first step, nurses should be acknowledged of common health problems associated with refugees in order for the nurse to be aware of certain symptoms and comorbidity, particularly psychological symptoms due to the high rate of mental health problems between refugee community. Acknowledging common comorbidity between refugees will also help the

nurse to avoid certain assumptions or stereotypes about cultures, like the assumption of the absence of substance abuse in certain cultures for example.

As a second step, nurses are advised to take interest in their refugee patient and into their culture when providing care for refugee patient. Having small conversation with the patient, inquiring about their previous healthcare experience, and showing interest in their culture are all important useful measures.

Nurses should be aware of the situation of refugees or asylum seekers in the host country. Asylum seekers may be afraid of deportation or they may carry fear of stigma from certain diseases and that may affect their openness regarding certain symptoms or current diseases. Nurses should explain that they have nothing to do with immigration services, and all health information are considered confidential and are shared only between healthcare personnel.

Understanding the social context of refugee is quite important for nurses in the assessment process. Loneliness, healthcare literacy, and adjustment difficulties are common problems for refugees and asylum seekers in the host country and providing psychological support for refugees during encounter are vital to create a trusting relationship with the health provider.

Being aware of the social and environmental constructs of refugees will assess the nurse in maintaining certain aspects of the refugee health believes and values “*Culture care preservation*”. Refugee may carry different concept of health or illness, and due to their previous experiences, they may expect different treatment pattern. Nurses should explain their role and explain the treatment process, as well as explain why the patient is experiencing certain symptoms and why the patient should adhere to the treatment instructions.

Orienting the patient about the healthcare system will help the patient engage into the treatment process and it will help the patient to understand and adopt to the current health culture in the host country “*Culture care accommodation*”.

Getting familiar with the culture of the refugee patient will help the nurse to understand important aspects inside the culture like gender relations, relationships inside the family,

and the role of traditional medicine, and utilize those aspects when providing care for refugees “*culture care repatterning*”. See Figure 10

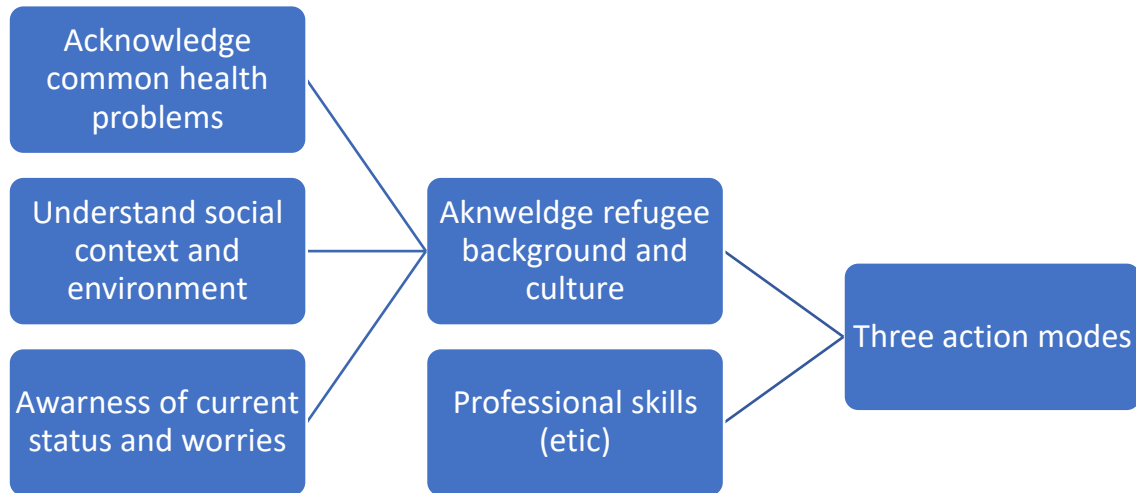


Figure 10

7.5 Previous studies on the subject

Some of the findings of this study resonate with the findings of another study regarding challenges facing refugees’ access to healthcare in Canada (McKeary, 2010) which identify barriers including language, cultural competency, healthcare coverage, availability of services, isolation, poverty, and transportation. In a separate study, the use of community health workers or multicultural health brokers was found to improve the health equity for marginalized populations such as new immigrants and refugees (Torres, et al., 2014). Another American study on the effectiveness of cross-cultural education for medical personnel providing care for Burmese refugees found that a brief intervention focused on cultural considerations in medical care may improve cultural competency when caring for vulnerable patient population (Mchenry, et al., 2016)

8 CONCLUSION

Language barriers, cultural differences, and referral pathways are the common barriers for care providers and for refugees during their encounter at the healthcare facilities.

Additionally, refugees consider the quality of care received, lack of information, and healthcare literacy as other barriers which affect the quality of healthcare. Both parties agree on the need for training and guidance to overcome these barriers. The use of skillful interpreting services, and the integration modern technologies to ease the process is vital solution to overcome the language barrier. Collaborating between services and sectors, and flexible exchange of refugee data is a step towards improving healthcare access to refugee, and an important factor to provide holistic care for refugee patient. Understanding the social context of the refugees is very important in the treatment process. Getting familiar with refugees' common health problem, their previous healthcare experiences, cultural concept of health, and cultural values and believes are all major steps in order to provide culturally congruent care for this vulnerable group.

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APPENDICES

The chosen articles which are reviewed in this study are listed below in alphabetical order.

1. Mohamud Sheikh-Mohammed, C Raina MacIntyre, Nicholas J Wood, Julie Leask and David Isaacs, 2006, *Barriers to access to health care for newly resettled sub-Saharan refugees in Australia*
2. Luke Robertshaw, Surindar Dhesi, Laura L Jones, 2017, *Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries: a systematic review and thematic synthesis of qualitative research.*
3. Alice Clark, Andrew Gilbert, Deepa Rao, and Lorraine Kerr, 2014, “Excuse me, do any of you ladies speak English?” *Perspectives of refugee women living in South Australia: barriers to accessing primary health care and achieving the Quality Use of Medicines.*
4. Megan S. McHenry, Rachel Umoren, Avika Dixit, Rachel Holliday, and Debra Litzelman, 2016, *Exploring Healthcare Perspectives of Burmese Chin Refugees.*
5. Meghan D. Morris, Steve T. Popper, Timothy C. Rodwell, Stephanie K. Brodine, Kimberly C. Brouwer, 2009, *Healthcare Barriers of Refugees Post-resettlement.*
6. Natasja Koitzsch Jensen, Marie Norredam, Stefan Priebe, and Allan Kransik, 2013, *How do general practitioners experience providing care to refugees with mental health problems? A qualitative study from Denmark.*
7. Kevin Pottie, Ricardo Batista, Maureen Mayhew, Lorena Mota, Karen Grant, 2014, *Improving delivery of primary care for vulnerable migrants. Delphi consensus to prioritize innovative practice strategies.*
8. Miriam Posselt, Karalyn McDonald, Nicholas Procter, Charlotte de Crespigny and Cherrie Galletly, 2017, *Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: addressing the barriers.*
9. I-Hao Cheng, Ann Drillich and Peter Schattner, 2015, *Refugee experiences of general practice in countries of resettlement: a literature review.*

10. Elisabeth Mangrio, and Katarina Sjögren Forss, 2017, *Refugees' experiences of healthcare in the host country: a scoping review*.