

# Understanding the health problems of Congolese Refugees

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Bachelor's Thesis  
April 2012

Degree Programme in Nursing  
Social services, health and Sport



Author(s)  Ndayishimiye Patrick Nshongore Nziza William	Type of publication Bachelor's Thesis	Date 04.04.2012
	Pages 49	Language English
	Confidential	Permission for web publication
Title  UNDERSTANDING THE HEALTH PROBLEMS OF CONGOLESE REFUGEES.		
Degree Programme in Nursing  Social services, health and Sport		
Tutor(s)  Irmeli, Katainen & Garbrah, William		
Assigned by  JAMK University of Applied Sciences, School of health and Social Studies		
Abstract  <p>The purpose of this study was to find out how the Congolese refugees experience their health as well as healthcare services. The aim of the study was to add these people knowledge, local authorities, health providers, social workers when planning care or services for refugees.</p> <p>The research method used to implement the study was qualitative method. In this study, standardized open-ended interview approach was used. Study participants consisted of three females and two males. Data collection lasted two weeks and a content analysis was used to analyze the data.</p> <p>The findings of this study demonstrated that participants came to Jyväskylä with a variety of health problems, including mental and physical problems and longstanding undiagnosed chronic illness. The findings of this study also indicated that most of the participants were satisfied with general care they received since they came to Jyväskylä but, nonetheless, the findings revealed that few of them were still complaining about the health care system which they described being slow.</p> <p>The results of this study could be utilized in providing relevant information to whoever will need to conduct further research. Results could also be useful to Jyväskylä immigration office, Central Finland hospital and other stake holders.</p> <p>Further research is recommended that could involve a broad participation of the healthcare providers, and thus some knowledge, not only Congolese refugees' perspective but also health professionals' perspective would be acquired.</p>		
Keywords: Refugee, health problems, Congolese, resettlement, healthcare services.		
Miscellaneous		

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# 1 INTRODUCTION

Refugee problem is a big challenge in 21<sup>st</sup> century. According to United Nations High Commissioner for Refugees (UNHCR), news stories claims that some forty million people worldwide are uprooted by violence and persecution, and the problem of human displacement is expanding and becoming increasingly complex. It is likely that the future will see further forced displacement. (UNHCR 2007.) "It is estimated that there are millions refugees in the world today, and twice those numbers of persons are displaced within their own countries" (UHCR 1996). People are forced to seek refuge for increasingly connecting reasons. They do not just flee persecution and war, but also injustice, exclusion, environment pressures, competition for scarce resources and the miseries caused by dysfunctional states. (UNHCR 2007.)

The refugees find themselves in long-lasting bad situation and it is horrible time for them to be in the new state of limbo without any hope of going back to their homeland because of insecurity and persecution. Even though refugees usually come from a large variety of different countries with different cultural backgrounds and health beliefs, values, social practices, tradition norms, and religion, they absolutely share common ongoing problems in their daily life. (Fred Chung & Paul 2002, 17.) According to UNHCR (2003), many people flee or escape from war and persecution; they are highly exposed to insecurity, physical and mental violence (UNHCR 2003).

The insecurity, physical and mental violence are the main cause of involuntary migration that lead to the cause of separation of family, downgrade in socioeconomic status, languages problems and acculturation problems especially in the new country of resettlement (Fred Chung et al. 2002, 17-19).

As nursing is becoming an international profession, it is very important to understand the health problems of different cultural backgrounds. The interest of the above topic was drawn from personal experiences as foreigners who live in Jyväskylä and who have observed how Congolese refugees are increasingly settled in Jyväskylä and becoming the clients of Jyväskylä hospitals. And also as student nurses doing practical training in Jyväskylä Central Hospital have noticed how the refugees of different backgrounds have health problems. This motivated the authors to visit the Jyväskylä immigration office where they presented the idea of the thesis and they were encouraged to conduct the research and authors found out that no study has been conducted before about Congolese refugee's health problems in Jyväskylä.

The purpose of this study was to find out how the Congolese refugees experience their health as well as healthcare services. The aim of the study was to add these people knowledge, local authorities, health providers, social workers when planning care or services for refugees. The results of this study could be utilized in providing relevant information to whoever will need to conduct further research. Results could also be useful to Jyväskylä immigration office, Central Finland hospital and other stake holders.

The study commences by exploring different concepts of health. The study presents also the history of Congolese refugees in Finland and their health concerns as well.

## 2 REFUGEE

The United Nations (UN) General Assembly defines the term refugee as “any person 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 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 fear, is unwilling to return to it”. (Unite for sight 2012).

While refugees living in their countries of origin, often experience traumatic events such as violence, torture, and the loss of loved ones, which frequently trigger them to escape and leave their home countries. Furthermore, refugees are frequently plagued by feelings of hopelessness, fear, sadness, anger, aggression and worry. (Unite for sight 2012.)

### 3 HISTORY OF CONGOLESE REFUGEES

The Democratic Republic of Congo (DRC) is a country that located in Central Africa and is nowadays the second largest country in Africa after Algeria. The capital city is Kinshasa. In entire world it is the eleventh largest country. It shares borders with nine nations including Zambia, Rwanda, Burundi, and Republic of the Congo, South Sudan, Uganda, Tanzania, Central African Republic, and Angola. The figure below shows the map of Democratic Republic of Congo.



Figure 1: Democratic Republic of Congo.

Source: lonely planet 2012

The population in 2011 was more or less 71 million, ethnic groups are approximately 250. Religions: Seventy percent Christian, ten percent of Kimbanguist, ten percent of traditional beliefs and ten percent of Muslim. The most common languages are French (official language), Lingala, Kiswahili, Kikongo, Tshiluba and others. Every ethnic group generally has its own native language, dialect and customs. (U.S. Department of State 2011.)



Until 1960 DRC was under the colonial rule of Belgium and then DRC got independency after decades of struggle. Since then, its history has been dominated by dictatorship under the presidency of Colonel Joseph Mobutu Sese Soku. He has ruled the country known as Zaire through the use of military force which was characterized by instability in government and regime has been characterized by corruption and human rights abuses. (Australian Government, department of immigration and citizenship 2006.)

Following the year 1994 Rwandan genocide in which 800.000 Tutsis and moderate Hutus were killed and hundreds of thousands Rwandan refugees fled into eastern DRC. Hutu rebels took control of the resulting refugee camps and used them as a base for buying arms and conducting cross-border raids into Rwanda. In 1996, the Rwandan and Ugandan government, concerned at the threat from these militia groups, began to channel arms to ethnic Tutsis in the east of DRC to counteract Hutu forces. They supported a rebellion led by Laurent Kabila that saw Mobutu's reign toppled in 1997. (Op.cit.)

Despite the end of war, eastern Congo has continued to be the spot of violence, poverty and disease. In 1998, again a regional war broke out between DRC government and Ugandan- Rwandan- backed rebels. As a result around 1, 8 million Congolese were internally displaced and around 300.000 fled to neighboring countries including Rwanda in the three different refugee camps Gihembe camp, Kiziba camp and Nyabiheke camp . (Opi.cit.)

In December 1998 more than 300 people were killed and other 207 wounded at Mudende refugee camp in Rwanda. The killings followed a previous attack in August, 1998 that left over 100 dead. Mostly, victims were children and women and were hacked to death in their sleep. After those killings the survivors were transferred by Rwanda government and UNHCR to those camps mentioned above. (UN 1998.) According to Rwandan officials the rebels from DRC were responsible of killings (UNHCR 1997).

In Burundi, in August, 2004 similar horrific killings of Congolese refugees happened and more than 150 refugees have been slaughtered in their transit camp of Gatumba, just 3 km from Burundian border with the DRC. (UNHCR 2005.)

In those camps, women and men are living the good life behind and facing the future challenge of hopeless. Most of them described being very sad and described being 'without hope'. Many women have lost husbands, children and some family members. ( Pavlish 2007.)

These Congolese men and women possessed farms, cows, sheep, goats and chicken. However, in camp they described being desperate and often feeling sick because they think too much and do too little. They described having power to work but no available jobs. (Pavlish 2007.)

Most of the DRC is now stable; but nonetheless the situation remains volatile in the east. The military operations against rebels continue to raise internal displacement and approximately more than 1.7 million people are internally displaced in eastern Congo. (UNHCR 2012.)

## 4 CONGOLESE REFUGEES IN FINLAND

According to International Organization for Migration (IOM), until the 1990s, Finland was mainly a country of emigration with a relatively small immigrant population. However, as a result of increasing immigration, Finnish government has slowly concentrated step by step on migration issues, leading to the appointment of the first Finnish Migration Minister in 2007 as well as centralization of migration issues under the Ministry of the Interior in 2008. (IOM 2011.)

Finland has accepted its first refugees in 1973 from Chile and in 1979 from Vietnam. An annual refugee quota was established with the UNHCR in 1986 and in Finland, an annual refugee's quota is 750 per year. (IOM 2011.) In recent years, Finland has accepted to resettle refugees from particularly nations from Iraq, Myanmar and DRC (Helsingin Sanomat 2007). Family members of quota refugees, who have been settled in Finland, are accepted in the country under family reunification program (IOM 2012).

Generally, the selection of the refugees is usually based on interviews conducted in refugee camps, during which the grounds for granting a residence permit are examined. A representative of the security police also participates in the interviews. The Finnish Immigration Service grants residence permits to refugees admitted to Finland within the refugee quota. (Finnish Immigration 2012.)

Finland has agreed and decided to settle 150 Congolese refugees who were living in Rwanda by 2008 and the refugee quota for 2008 supposed to be confirmed in connection with the drafting of the national budget (Helsingin Sanomat 2007).

Most of Congolese refugees who moved to Finland since 2007 are mostly from Eastern DRC and some of them are survivors of double brutal killings in

Rwanda and including those from Burundi (UN 1998). From 2006 – 2010 Finland has settled 587 Congolese refugees. These statistics does not include the Emergency and Urgent quota referrals (Finnish immigration 2012).

Congolese refugees, who have been settled in Finland, live in different cities including Jyväskylä. Jyväskylä city is located in Central Finland and is well known as a safe and pleasant place to live. The residents of the city enjoy a wide diversity of good quality services include culture, social, education and health services etc. (City of Jyväskylä 2012.)

To the city's reception agreement, about 50 refugees arrive in Jyväskylä each year (City of Jyväskylä pages 2012). According to Turtianinen (2012), Jyväskylä city encompasses 3047 foreign born citizens including 126 Congolese. Most of Congolese who live in Jyväskylä are refugees, 61 male and 65 female. She emphasized that they are expecting to receive 16 more Congolese refugees from Rwanda within this year of 2012.

## 5 REFUGEE'S HEALTH PROBLEMS

In a refugee crisis, many people have to leave suddenly their homes and countries due to conflicts. Most of them flee to save their lives and later become refugees. Throughout the period of escaping, many refugees suffer physically from hunger, injury and injuries as well as psychological harm. (UNHCR & WHO 1996.).

In the past, concern has often focused on the deaths, physical diseases and traumas that resulted from wars and disasters but nowadays there is also growing concern about the psychosocial and mental health consequences. Such consequences are not always short-lived; some can last a lifetime and some may even have an influence on the children of those affected". (UNHCR & WHO 1996.)

In the early phases of war and persecution, many refugees are at risk of potentially fatal diseases and that lead to extensive loss of life. The major health problems of refugee are acute respiratory infections (pneumonia), malnutrition, malaria (where prevalent), measles, and diarrhea diseases (including cholera). Other deadly health problems include meningitis, tuberculosis, pregnancy and obstetric complications, vector-borne diseases, as well as vaccine-preventable childhood diseases. (UNHCR 2003.)

In addition, the eruptive situation in which many displaced people find themselves tends to place them at greater risk of sexual violence, unwanted pregnancies and resulting in the accelerated spread of sexually transmitted diseases (UNHCR 2003).

Refugees face various health problems but the most common are mental health problems (WHO 2011). It is estimated that more than 50 percent of refugees manifest mental health problems ranging from chronic mental disorders to trauma, distress (WHO 2011). The migration trajectory can be

divided into three phases: Pre-migration, migration and post migration resettlement. Each phase is characterized by specific risks and exposures but the research focused more on post migration resettlement.

Pre-migration	Migration	Post-migration( after resettlement)
<b>Adult</b> Economic, educational and occupational status in country of origin	Trajectory( route, duration)	Uncertainty about refugee status
Disruption of social support, roles and network	Exposure to harsh living conditions( e.g., refugee camps)	Unemployment
Trauma(type, severity, perceived level of treat, number of episodes)	Exposure to violence	Loss of social status
Political involvement( commitment to a cause	Disruption of family and community networks	Loss of family and community social supports
	Uncertainty about outcome of migration	Concern about family members left behind and possibility for reunification. Difficulties in language learning, acculturation and adaptation( e.g., change in sex roles)
<b>Child</b>		

Age and developmental stage at migration	Separation from caregiver	Stresses related to family's adaptation
Disruption of education	Exposure to violence	Difficulties with education in new language
Separation from extended family and peer networks	Exposure to harsh living conditions( e.g., refugee camps)	Acculturation (e.g., ethnic and religious identity; sex role conflicts; Intergenerational conflict within family) Discrimination and social exclusion ( at school or with peers)

Table 1: Factors related to migration that affects refugees mental health.

Once resettlement is decided usually brings optimism and hope to refugees, which can have a positive effect on their health and well-being.

Disillusionment and depression can occur early as result of migration which is associated with losses, or later, when initial expectations and hopes are not met. In this phase, refugees face enduring obstacles such as structural barriers and inequalities aggravated by exclusionary policies, discrimination and racism, social alienation, social and economic strain, status loss and exposure to violence. All these obstacles encounter difficulties among resettled refugees in their new home which can contribute the re-emergence of anxiety, depression of post trauma stress disorder. (Medical knowledge that matters 2011.)

According to Ater (1998) there is a significant level of psychological stress among refugees with relatively high degrees of physiological dysfunction and physical during the first two years of resettlement. He highlighted also that there are some improvement and increasing adaptability after three years, he stressed also that it can be still serious problems affecting some sectors of the refugee population such as high levels of depression, somatization and post-traumatic stress disorder even after five years of resettlement.



## **6 HEALTH PROBLEMS AND BARRIERS TO HEALTHCARE SERVICES AMONG REFUGEES AFTER RESETTLEMENT**

According to IOM (2010), the resettlement is helping refugees to begin a new life in a new country, and resettlement begins with the processing of refugee's requirements and ends with their placement in a local community in country that has accepted them for permanent settlement (IOM 2010).

According to World Health Organization (WHO), less than 1% of refugees are essentially selected for resettlement in a third country. Most of refugees remain in refugee camps for short to long period. To be eligible for resettlement, refugees are selected by the UNHCR undergo an interview with an immigration officer representing the resettlement country. (WHO 2012, 34.)

Refugees come to host countries with vastly different health problems than the countries' native-born populations. Refugees often come from conflict areas and long term stays in refugee camps, with diverse access to adequate health care. Many experienced trauma, including torture, family separation, violence and rape. (WHO 2012, 34.)

According to Turtiainen (2012) most Congolese refugee's women have physical and mental problems because there are victims of sexual violence and other abuses in their country of origin. Congolese refugees are often depressed and it is difficult to cope with their everyday life. Sometimes, they are afraid and ashamed to speak about these problems. She highlighted that the most health problems affecting Congolese refugees are due to pains, bad memories, sleeping problems and anxiety. In Addition, she emphasized that refugees from DRC are quite victims of torture and other serious violations which affect a lot to their mental health.

As illustrated by WHO (2012) refugees increasing stress in their new country due to many barriers which influence refugees' health such as language and communications barriers, cultural beliefs, socio-economic, and education. These barriers and personal experiences affect their mental and physical health directly but also indirectly impact their health by limiting access to health care services. (WHO 2012, 34.)

The ability to access healthcare depends on their knowledge and understanding the healthcare systems in their new country. However, in the early settlement period most refugees will specifically require intensive support. Ideally, this includes basic settlement incomes support, reception accommodation and orientation of basic health care until resettled refugees become self-sufficient. (UNHCR 2002.)

According to WHO (2009) even though refugees begin new life in host country they may have health needs related to their refugee status and may not have the language abilities or skills common among other types of migrants. The crucial challenges for health providers and stake-holders in resettlement societies is how to reach newcomers, in particular refugees and asylum seekers who may be isolated by language or lack of knowledge about the local health care services. (WHO 2009.)

The refugees who are not familiar with the health-care system may interpret relatively innocent events as evidence of racism or discrimination if they are not sufficiently explained by healthcare providers. For example, long waiting in an emergency department to be consulted by physician can be interpreted negatively as discrimination. These bad experiences may result in avoidance of seeking health care services. (WHO 2009.)

## 7 DETERMINANTS OF HEALTH OF REFUGEES

The health and well-being across all age groups of individuals and populations is influenced by a range of factors both within and outside the individual's control. One model, which captures the interrelationships between these factors, is the Dahlgren and Whitehead 'Policy rainbow', which describes the layers of influence on an individual's potential for health. (Healthknowledge 2012.)

Therefore, the focus of the research could be zeroed only on four barriers which were used as determinants of health including socio-economic, education, language and communication, cultural beliefs refer to figure 2.

Whitehead (1995) illustrated these factors as those that are potentially modifiable factors such as personal lifestyle, the physical, social environment, wider socio-economic, cultural and environment conditions. He also illustrated fixed factors such as age, sex, genetic. (Healthknowledge 2012.)

Health and wellbeing are the consequence of a wide range of factors, summarized in the rainbow model figure below.

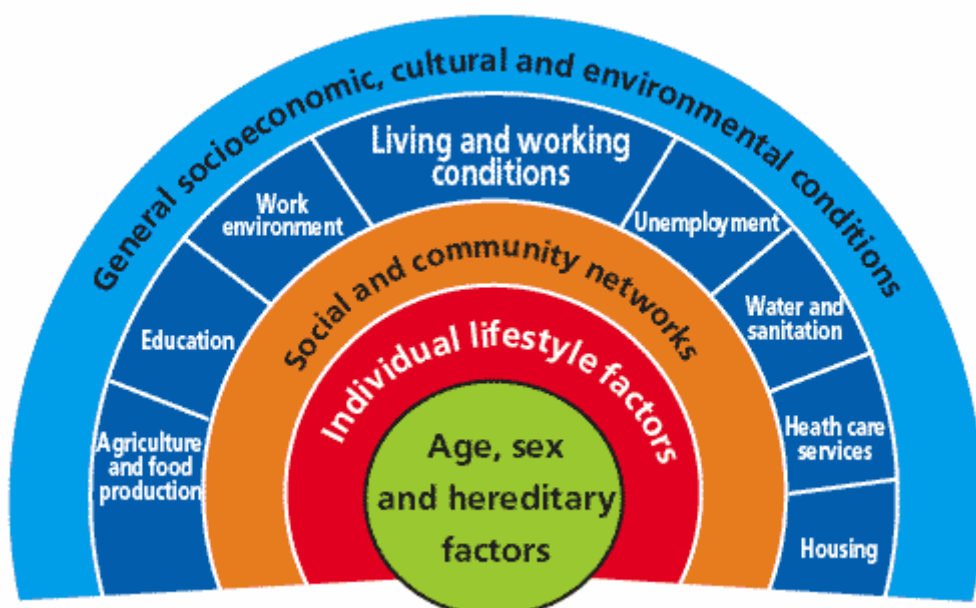


Figure 2: Rainbow model of Health (Dahlgren and Whitehead, 1991)

The Dahlgren and Whitehead model has been effective in providing a framework for raising questions about the size of the contribution of each of the layers to health. (Healthknowledge 2012.)

Therefore, the rainbow model is developing more comprehensive understanding of factors influencing health which can even evoke some barriers in accessing healthcare services.

## 7.1 Socio-economic Barriers

Social support of refugees is a key determinant of health, and is as vital to maintaining wellbeing as food, shelter, income, personal security, and access to health care and social opportunities. As a coping resource, social support protects against physical and mental health risks. Even when supportive social ties are merely a potential source of help, social support preserved availability encourages successful coping with stressful situations.

Conversely, social isolation and lack of social ties from which support may be drawn have long been associated with reduce psychological wellbeing.

Different coping styles and methods influence how the newcomers handle stress and seek social support when needed. Personal resources such as education, life experiences and family circumstances influence how stress is appraised and handled. (Doucet 2004.)

Usually, refugees are presumed to be at great risk for mental illness due to pre-migration experiences, exposure to violence and traumatic situation in their homelands. Apparently, social factors affecting the mental health of newcomers into their new host communities are also major concern and

mental health care providers should take it into consideration. (Simich, Hamilton & Baya 2006.)

Even though income inequality affects population health and mental wellbeing, there is slightly evidence of how deprivation and poverty influence the mental health of refugees during resettlement. Studies which focus on the mental health of refugees after settled in Europe, for example, indicated that social disadvantages such as economic difficulties and low incomes are related with psychological distress and mental problems. (Simich, Hamilton & Baya 2006.)

## **7.2 Education Barriers**

Generally, education is an indispensable key of success around the world. As refugees come from war-affected areas and schooling environments which were often interrupted, resettled refugees have specific barriers and needs to overcome in order to have a better education ahead. For example, a study among African refugee students which had been conducted in Manitoba (2008) found that economic, academic and psychosocial problems which they were facing affected their ability to integrate and cope well in school. (Unite for Sight 2012.)

Thus, education problems are the main cause of reducing socioeconomic opportunities among resettled refugees. Another study that had been conducted in U.S at Phoenix, Arizona (2009) found out that language barriers were one of the greatest problems to success in the new societies and especially the ability to be successful in school. (Unite for Sight 2012.)

### **7.3 Language and Communication Barriers**

In resettlement phase, the communication is seen as a primary barrier of seeking healthcare services. Language and communication affect all steps of healthcare services access, from making a rendezvous to filling out a medical prescription. The inability to communicate is not only crucial for making an appointment and have access to the system, but it can also be critical for medical compliance. (Unite for Sight 2012.)

The misinterpretation of healthcare providers has an impact to the quality of care they are able to provide. Hence, it is difficult to properly diagnose patients when communication skills are broken and the time of physician is limited. (Unite for Sight 2012.)

In the medical area, communication is often listed as one of the main barriers to providing adequate health care to resettled refugees (Steimel 2011).

### **7.4 Cultural Beliefs as Barriers**

A study which has been conducted in San Diego (2010) revealed that cultural barriers have immediate impact on refugee's health. Very often refugees are not familiar with preventive care, and they often seek care when they are very sick. Because of stigmatization and lack of understanding about mental health conditions, they rarely seek care for mental health diseases. It's very difficult for refugees to adjust and to adapt the new health care system in their new host country due to their background experiences. Refugees usually have different explanations for the causes of health and illness, which might also impact utilization of western medical services. (Unite for Sight 2012.)

Language and communication barriers related to cultural beliefs are

increasingly recognized as problems between health care providers and patients (Lee 2003).

Although Cultural belief and linguistic barriers can be overcome through the use of interpreters, translators, and cultural brokers, but incorrect interpretation can provoke stress among refugees and it can make diagnoses and achieving medical compliance even more confusing (Unite for Sight 2012).

Often children serve as translators or interpreters for their parents because they learn quickly the new language and adapt quite easily the country of resettlement. However, use of children as interpreters gives them more responsibilities, which triggers unnecessary amount of stress. Children who play the role as translators are highly exposed to a position of great power which lead to power battles within a family and loss of authority of parental figures. (Unite for Sight 2012.)

## 8 FINNISH HEALTH CARE SERVICES

The aim of health care services in Finland is to maintain and enhance people's physical and mental functional capacity. The system is fundamentally based on preventive health care and well-run in order to keep patients healthy and fit as well as comprehensive health services. (Ministry of Social Affairs and Health 2012.)

The Ministry of Social Affairs and Health (MSAH) in Finland is chargeable for all healthcare issues in entire country and supervises all social and health services. MSAH will evolve and implement healthcare policy and ensure all healthcare reform is accomplished. (Health protection around the World 2012.)

In Finland, healthcare services are available to all residents, despite of their financial situation. It comprises primary healthcare services, run by municipal health centers, specialized hospital care, public health care and private health care. (Teperi, Porter, Vuorenkoski & Baron 2009.)

Primary health care is the responsibility of healthcare centers. The municipalities have their own health centers which provide services to their residents including physical examinations, oral health, medical care, ambulance services, maternity and child health clinics, school and student health care and other basic services. (MSAH 2012.)

Specialized medical care is provided in hospitals, throughout inpatient and outpatient departments. The wide ranges of specialized services vary based on type of hospitals. Each central hospital arranges specialized care services in its area. There are 20 districts central hospitals, around 40 other smaller specialized hospitals and 5 university hospitals that provide specialized tertiary levels of treatment in whole country. (Järvelin 2002.)



Private health care treatment supplements care provided by state and municipalities. Particularly, private care is offered in cities by some doctors, dentists, and physiotherapists. There are also a few small private hospitals and part of the cost is reimbursed to clients from health insurance. (Finnish Medical Association 2012.)

The government social insurance agency Kansaneläkelaitos (KELA) assists all residents to pay the health care services. The residents will need to obtain a KELA card in order to get reimbursement of medical costs. (Expatriate Finland 2012.)

## 9 PURPOSE, AIM, AND RESEARCH QUESTIONS OF THE STUDY

The purpose of this study was to find out how the Congolese refugees experience their health as well as healthcare services. The aim of the study was to add these people knowledge, local authorities, health providers, social workers when planning care or services for refugees. The results of this study could be utilized in providing relevant information to whoever will need to conduct further research. Results could also be useful to Jyväskylä immigration office, Central Finland hospital and other stake holders.

Study questions are:

- ❖ What are the Congolese refugee's experiences of their health?
- ❖ What are the experiences of Congolese refugees about the healthcare services?
- ❖ What are the expectations of Congolese refugees about the healthcare services?

## 10 IMPLEMENTATION OF THE STUDY

### 10.1 Qualitative method

Qualitative research method was used in this study. Qualitative research method seeks to understand a topic or a given research problem from the perspectives of particular population if involves. (Family health international 2005.) According to Woods (2006), the qualitative researcher seeks to discover the meanings that target group attach to their behavior, how they overview situation, and what their perspectives are on particular issues.

For instance, Corbin & Strauss (2008) states that qualitative research methods permit researchers to get the inner experience of participants, to conclude how meanings are formed through and in culture. (Corbin & Strauss2008, 12.)

Since the purpose of the study was to find out how the Congolese refugees experience their health, qualitative research method was suitable as it allows the participants to express freely their health concerns as well as their experiences.

Moreover, qualitative research is principally effective in obtaining culturally specific information about the opinions, behaviors, values and social contexts of particular populations. (Family health international 2005,1.)

Qualitative research uses the natural setting as the source of information. The researcher makes effort to observe, describe and interpret settings as they are, maintaining empathic neutrality. Empathy involves being able to take and understand the stance, feelings, experiences, and worldview of others. (Patton 1990, 55-56.)

The data collected from qualitative research aids to understand the experiences or phenomena that affect participant's daily life. As a result these

data could be utilized to obtain information in context, gain knowledge, process it and interpret, in order to improve care for specific population and used for further research. (Lobiondo-Wood & Haber 2006,28.)

## 10.2 Study Participants

The participants of the study were drawn from the Congolese refugees residing in Jyväskylä town. The researchers accessed the study population through personal contacts. Five individuals took part in the interview for the study. They consisted of three females and two males aged between 20 – 40 years who have lived more than two years in Jyväskylä. They had to speak either Kinyarwanda or French.

The selection of participants was based on non-random designs also called purposive sampling. As illustrated by Tongoco (2007), the purposive sampling technique also judgment sampling, is the deliberate choice of an informant due to the qualities the informant possesses. ( Tongoco 2007 ,148.)

The fundamental consideration in purposive sampling is a researcher judgment as to who can provide the best information to achieve the objectives of the study. A researcher only goes to those people who are likely to have the required information and be willing to share it. Purposive sampling is tremendously useful when a researcher want to construct a historical reality, describe a phenomenon which only a little is known. (Kumar 2011, 207.) Therefore, the purposive sampling was appropriate to this study since it allowed the researchers to choose the participants who had qualities of information and willing to share them.

### 10.3 Data collection

Data collection is an important step of finding people to study and establish rapport with participants in order to provide a good data. Furthermore, data collection offers one more instance for assessing research design within each approach to inquiry. (Creswell 2007,117-118.)

According to Patton (1990), there are three basic approaches to collecting qualitative data through open-ended interviews: the general interview guide approach, the informal conversational interview, and the standardized open-ended interview. (Patton 1990, 280.)

In this study, standardized open-ended interview approach was used refer to appendix 1. It consists of a listed questions cautiously worded and arranged with the intention of taking each participant through the same sequence and asking each participant the same questions with basically the same words. This minimizes the possibility of bias which comes from having different interviews for different participants. (Patton 1990, 280-85.)

According to Patton (1990), the standardized open-ended interview makes data analysis easier because it is possible to locate each participant's answer to the same question rather quickly and to organize questions and answers that are similar (Patton 1990, 285).

In this study, a pilot study was conducted, since the guide questions were translated to French and Kinyarwanda, a slight change was done in order to make clear or harmonize the questions to the participants. As illustrated by Polit and Beck (2004), pilot study called also feasibility study is a small experiment designed to test data collection instruments and sample recruitment strategies. Therefore, pilot study helps the researcher to provide evidences about the success of the intervention, and about ways in which the intervention can be modified or strengthened. (Polit & Beck 2004, 196.)

In this study, a prior arrangement was organized in order to ensure the participants have sufficient information about the study. At the same time, researchers contacted the participants via phone calls in order to provide more information about the study. A consent form was provided to the participants who consented verbally. By and by the researchers and participants agreed on time and area for the interview.

The interview questions were prepared in English and researchers translated them in Kinyarwanda and French as participants could not speak or understand English. All five interviews were conducted in participants' homes from 09 March to 23 March 2012 and all were tape recorded. Each interview lasted between 30 – 40 minutes and the need of interpretation was not required as participants and researchers spoke and understood either Kinyarwanda or French.

## **10.4 Data analysis**

The way data is analyzed depends on the way it was collected and it contributes to analysis, interpret and later produce findings of the study. Data analysis of qualitative research process brings order, structure, and interpretation to the mass of collected data. (Marshall & Rossman 1999, 150.)

In this study content analysis was used. Content analysis is a process which identifies, codes, and categorizes the primary patterns in the data, this means analyzing the content of interviews. (Patton 1990, 380.) According to Smith (2000), Content analysis is a technique that draws wanted information from a body of material (usually verbal) by objectively and systematically identifying specified characteristics of the material (Smith 2000, 314).

Audiotapes were transcribed from French, Kinyarwanda to English after all interviews for data analysis. One interview was in French and four interviews were in Kinyarwanda. Transcribed interview notes produced approximately 4 A4 page notes per each interview. The interview tapes were transcribed word by word, some information such as names and significant others which could easily reveal the participants' identities were left out. According to Polit and Beck (2004), audiotaped interviews and field notes are major data sources in qualitative research. They further stressed that verbatim transcription is a crucial step in preparing for data analysis. And they emphasized that researchers need to ensure that transcriptions are accurate, and reflect the totality of the interview experience, in order to facilitate effective analysis. (Polit & Beck 2004, 572.)

After the interviews were transcribed, the next step was assigning different colors to the transcribed notes. Color highlighting marks were used in order to distinguish each piece of the transcript text allocated to a theme. After the coding process, a summary of the participants' responses was made and each response was sorted under each theme (Appendix 1.)

According Creswell (2007) data analysis in qualitative research approach consists of preparing and organizing the data for analysis. It reduces the data into themes via a process of coding and condensing the codes. Finally, represents the data in a discussion, figures, or tables. (Creswell 2007, 148.)

## 11 FINDINGS

### 11.1 Participants' background

The participants were drawn from Congolese refugees living in Jyväskylä. The researchers accessed the study population through personal contact. Five individuals were taken part in the interview for the study, two males and three females. The age ranges between 20 – 40 years old who have lived 3 to 7 years in Jyväskylä. The participants spoke either Kinyarwanda or French.

### 11.2 Participants' experiences of their health

Most of the participants have moved to Finland with background history of health problems and some of them were still in healing process. Majority's health problems were linked with chronic diseases, wars and brutal killings that happened while they were still living in their home country or in host camps. They mentioned that they have lived a hardship period of escaping, thus it was evident that many participants were still suffering from both physical and mental injuries. Some of them expressed that they had received bullet wounds that severely impaired their ability to move their hands, arms and legs, others still complained of significant pain.

This is illustrated by the following comments:

*“Yes definitely that's why I have left Africa and settled to Finland, because I was very sick, my health couldn't allow me to stay there”*

*“First, I was psychologically sick because of war which was undergoing in my country and I was forced to flee. Secondly, I was physically sick as well, they have tortured and beaten me on my stomach, since then, I have never been okay even here in Finland.*



Most of the participants came to Finland with hope of getting a good treatment, some of them emphasized that they are still struggling with their health problems. One participant stated that

*“To be honest, I myself, I didn’t have any health problems but one of my relatives was sick because she has been wounded by bullet in her arm while we were in camp and she has been operated in Africa but she didn’t get well at all. When she arrived in Jyväskylä, doctors told her that her arm was already incurable. And just referred her to physiotherapist and still now she is in a process of therapy”.*

*“.....I am wondering if Finnish doctors know how to treat Dysenteric disease! Because, I was under treatment in Rwanda. But here in Jyväskylä, they always keep telling me that am okay. If I could have enough money I could go back to sick treatment over there”.*

Most of participants expressed also that the major problem they are facing these days related to mental health mainly due to depression, traumas, cultural differences and other stresses of life. They are very worried how they are going to overcome that situation and complained not having opportunities to work and pursue their studies further due to language problem and for those who came in with high education complained not getting job straight away after they finish Finnish language course. Most of them stated that, even though there are here in Jyväskylä their minds are somewhere else because of their relatives who are still in Africa and emphasized that reunification has become the major issue for them as they have to wait for long time. One participant had this to say:

*“.....Even when you decide to study in order to have a profession, the language also raise as a big problem”.*

*“.....For instance, like me who is in middle age, to study Finnish language, then professional schools and university, I see myself finishing it and get immediately retirement..... No hope No future”.*

Most of the women interviewed have revealed that although they are in a new country with new life, they still have sorrows due to violence which they went through and even they clearly explained to have been tortured, abused but were somehow difficult for them to describe what kind of abuses they have undergone.

One participant had this to say:

*“I went through bad things, I wish no woman could face such horrible things”.*

### 11.3 Participants experiences of healthcare services

Most of participants share a common view about healthcare services. They stated that when they moved to Jyväskylä, they have been taught at school and even from immigration office how to access healthcare services. Some of them were happy and satisfied with the healthcare services they have gotten. And they were aware how healthcare system works. They expressed their views in following comments:

*“.....personally, I was so impressed how they treated me when I arrived in Jyväskylä, especially with the high technology that was different from my country even where I have been living before coming to Finland”.*

*“ I went through general checkup and it was my first time to go through it.....they gave me a medication card for buying the medicines in pharmacy for one year and when you fall sick you don't worry about money because there is KELA which covers medical costs..... “Life first Money after”.*

Few of them stressed that they have undergone different barriers of accessing healthcare services. They illustrated that here in Jyväskylä the obstacles of getting treatment remain big issues for them because when they go to seek treatment; they usually undergo several examinations that take time to find out the cause of sickness. Participants also highlighted that though healthcare services are good but still many things could be done. They were unhappy how they have to wait for long appointments, especially when they are strongly in need of treatment. Some of them also cited some main barriers such as cultural beliefs, and communication between them and healthcare providers which influence their health. They considered them as their main preoccupations. They clearly expressed their thoughts in these following comments:

*“The results are always negative, negative, negative..... and nothing, nothing... even when you feel seriously ill and I came up with a conclusion that I am sick of Negative”.*

*“ Most of us we speak Kinyarwanda but we don't have enough interpreters and usually they come from Helsinki. And they often provide for us the Swahili interpreters who are difficult to understand..... they speak different Swahili (slang)”.*

*“It is not good to wait for long time to meet a doctor when you feel over pain and you need immediate help.....Their system is too slow”*

## **11.4 Participants' expectations of health care services**

Most of participants expressed that they have met their expectations due to assistance from healthcare providers. They emphasized that they have been treated effectively as they were expecting and were so thankful of treatment they got. They described themselves as lucky ones as they can nowadays access to better treatment which is absolutely different from where they used to be. One participant had these views to express:

*“I have been operated several times while I was a refugee in Africa and I didn't get well but after arriving in Jyväskylä, it took me almost one year to recover..... I am now a healthy woman”.*

Some participants' expectations were not met immediately because they were highly expecting more and thought that they are going to recover in few days which were not the case. One of the participant's views is expressed as follows:

*“When arrived in Jyväskylä, I knew that I have lung problem, because I have been diagnosed while I was living in camps. I had strong feelings that I will get good treatment here in Finland but unfortunately it took them almost 8 months to find out the problem. Within those 8 months it was always negative and that brought to me in a deep depression..... I was not able to learn Finnish language”.*

The majority of the participants were satisfied with healthcare services they got but thought that the process of accessing doctors could be shortened in order to improve the services and make it faster.

“If there is a shortage of doctors why they can’t find more? ”.

## 12 DISCUSSION

The purpose of this study was to find out how the Congolese refugees experience their health as well as healthcare services. The aim of the study was to add these people knowledge, local authorities, health providers, and social workers when planning care or services for refugees. According to the findings of the research, participants revealed that they came to Jyväskylä with different health needs and there was a general consensus among participants that the health problems they have, are mainly linked with chronic disease, wars and brutal killings that happened while they were still living in their home country or in host camps.

The findings of this study also revealed that most of them still have physical and psychological problems which have delayed their recovery process. It was clear in findings that the physical and psychological pains remain their big fear and so far slow down their integration into Finnish society. This study demonstrates that participants came to Jyväskylä with a variety of health problems, including mental and physical problems and longstanding undiagnosed chronic illness.

Mental and physical health problems were the main problems which participants experienced. There is evidence that refugees present to the medical services with psychosomatic illnesses than native patients. This may be attributable partly to the higher rates of physical presentations of underlying psychiatric problems found in emerging countries. (Nwachukwu, Browne & Tobin 2009, 2.)

There is a significant level of psychological stress among refugees with relatively high degrees of physiological dysfunction and physical during the first two years of resettlement (Ater 1998). The findings of the study also highlighted that the most of participants had enough knowledge of how the

healthcare system works and were overall satisfied by the healthcare services offered by healthcare providers. Despite, the satisfaction of most of participants, the findings of the study also revealed the dissatisfaction of some participants mainly due to barriers which influence their health when seeking treatment, such as long waiting appointments, cross-cultural understanding, language and communication. Hence, these barriers could contribute to withdraw from seeking treatment.

Communication is a basic barrier encounter by refugees when seeking healthcare services. From making an appointment to filling out a prescription the ability to communicate in the country of resettlement is very crucial because communication affects all stages of healthcare services. (Unite for Sight 2012.) In the findings, few of the participants expressed to be dissatisfied with interpretations. Incorrect interpretations can sometimes make diagnoses more confusing and slows achieving medical compliance and that can cause unnecessary stress in refugees. (Op. cit.)

The findings of the study noted that some of the participants had difficulties in explaining their health concerns, thus this may affects the medical compliance. Healthcare providers do not necessary have to agree with the particular beliefs of their patients, but they must know that other opinions and explanations exist concerning health and illness apart from the western biomedical understanding. In this way, cross-culture understanding and culture competence is an important vehicle for achieving patient's satisfaction, and improved health outcomes. (Op. cit.)

The findings of the study also found that most of participants were satisfied with general care they got since they came to Jyväskylä but, nonetheless, the findings revealed that few of them were complaining about the health system which they described being slow. The study uncovered that some of them

suggested that the process of accessing physician's consultation could be shortened in order to enhance the services and gain high quality of care.

The refugees who are not familiar with the health-care system may interpret relatively innocent events as evidence of racism or discrimination if they are not sufficiently explained by healthcare providers (WHO 2009).

## **12.1 Ethical considerations**

Ethical issues are present in any type of study. Ethics is always associated with to doing well and protecting the anonymity and confidentiality of the participants. Creswell (2007) illustrated that in ethical issues, a researcher protects the anonymity of the participants by assigning assumed names to individuals. It also encourages a researcher to develop a case study of individuals that present a composite picture rather than an individual picture. (Creswell 2007, 141.) In addition to gain support from informants, a researcher conveys to informants that they are participating in a research, explains the general purpose of the study (Creswell 2007, 142).

In this study, the researchers ensured that ethical considerations were appropriately addressed. The researcher has a moral obligation to keep safe the participants anonymous from others. The data collected must remain confidential and the researcher must be aware that the anonymity and confidentiality are the only two main ethical issues to consider if the right of individuals is not to be compromised. (Parahoo 2006, 337.)

The researchers accessed the study population through personal contact but the results were not affected by that. At the same time, researchers contacted the participants via phone calls in order to provide more information about the purpose and aim of study. Additionally, the researchers explained to

them that the results of the study will be presented at the JAMK University of Applied Sciences, School of Health and Social Studies. A copy of the study will be available in the Library for the School of Health and Social studies.

A consent form was also provided to the participants explaining that the participation is voluntarily. The consent form explained that the confidentiality and anonymity will be maintained. The form also explained clearly that the information received will be published but the names of the participants will not appear in the study results. It was also clear in the consent form that the recorded tapes will be erased afterward and participants are free to withdraw the participation at any time if they feel so.

Therefore, the participants were aware of the nature of the study and thus gave the verbal consent. Morse (1994) stated that the principal consent form is important in any kind of human research. In essence, participants need to have accurate information about benefits and risks, the character of their potential participation, and the purpose of the study to make a decision about whether or not they will participate. (Morse 1994, 343.)

## **12.2 Credibility, Transferability, and Confirmability**

The trustworthiness of a study is very crucial to evaluating its worth. The trustworthiness of qualitative data involves establishing credibility, transferability, and confirmability. Credibility refers to confidence in the truth of the findings. Whereas transferability shows that the results have applicability in other contexts. Confirmability is a degree of neutrality that the results of a study are shaped by the participants and not researcher bias, or motivation. (Robert Wood Johnson Foundation 2008.)



Credibility, transferability, and confirmability are very important for this study in order to come up with relevant findings. Therefore, the pilot study was tested and the researchers ensured that the research questions were clearly and adequately answered. The study informants were sampled throughout personal contact. Informants were free to participate and were flexible to choose spot and time of the interview. The misunderstanding was reduced as researchers and informants used the same language. To make the study research clear and understandable, the findings were divided into themes in order to group the accurate information.

### **12.3 Conclusion and recommendation**

It was clear enough in the study that Congolese refugees have many health problems that related to mental and physical health conditions. The researchers found out that even though the physical health problems persist in Congolese refugees but the mental health is a major concern. In general Congolese refugees seem to go through horrific background history due to traumatic events. This affirms the findings of earlier studies which had uncovered similar results.

It might be so that the healthcare providers concentrate to treat physical pain rather than psychological pain. However, to eradicate or reduce the traumatic events among Congolese refugees, the knowledge about trauma and torture and its physical and psychological pains is very important. Therefore, the immigration office and other stake-holders could establish a trauma center which could be more active by assessing their client's particular needs, concerns and organize the psychological support or care. As it was uncovered in findings, poor health can serve as a significant barrier to integration, therefore, by assisting the Congolese refugees to deal with the practical and

emotional demands can simply contribute achieving an optimal health within Congolese refugee population.

The study also demonstrated that participants had enough knowledge regarding the use of healthcare services. Nevertheless, it seemed that they lack some information which may contribute to misunderstanding with healthcare providers. Therefore, the immigration office together with health professionals and other stake-holders could provide education for them in order to enhance their knowledge and comprehension about health care system in Jyväskylä.

The study recommended further research which could involve a broad participation of healthcare providers, and thus some knowledge, not only Congolese refugees' perspective, but also health professional's perspective would be acquired. This will help to promote holistic care of refugees and improve the knowledge of healthcare providers about refugee health problems in general. The study also recommended the City of Jyväskylä and Jyväskylä immigrant services alongside with healthcare providers to use the senior refugees as mentors of new arrivals in order to help the newcomers to cope with their daily activities which will significantly contribute to promote the health of refugees.

To conclude, Finnish government, City of Jyväskylä, immigration office in Jyväskylä, and other stakeholders should come together hand in hand in order to develop a sustainable healthcare promotion of settled refugees.

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# APPENDICES

## Appendix 1: Topic guide questions

### Participant's experiences of their health

- **Warming up question:** What do you know about health?
- Have you had any health problems history before you moved to Finland?
- What was the problem?
- Did you get treatment?
- Were you satisfied with the treatment you got?
- When you moved to Finland, have you come with any health problems?
- If yes did you get an accurate treatment of it?
- What health problems do you have nowadays?
- What first action you plan when you fall sick?
- Are there any barriers have you experienced seeking treatment? If yes please describe them in details?
- What kind of health problems are you afraid to discuss with the healthcare providers?
- Do you think your culture belief affects your health in general?
- Are there any psychosocial problems that affect your ability to integrate and cope well at school?

### Participants experiences of healthcare services

- Since you moved to Jyväskylä did you get any information about the use of healthcare services?
- What do you know about healthcare services?

- What was your first experience when you visited healthcare centers/hospitals?
- Were you satisfied with healthcare services you got?
- Do you have good or bad experiences about healthcare services since you moved to Jyväskylä? If yes could you please describe them in details?
- Are there any barriers which limit you to access healthcare services?

### **Participant's expectations of healthcare services**

- Compare to your background healthcare services experiences what was your first expectation during your first visit to Jyväskylä health care services?
- Did you meet your expectations? IF yes/no please explain why?
- Do you use interpreters during your visit at health centers/hospital?
- Is it okay for you to use them? If not please describe why?
- In your opinion, what are your suggestions, concerns, thoughts even wishes in order to improve your health status and healthcare services?



## Appendix 2: Consent form

I am signing this consent form to give permission to students to carry out a research study about understanding the health problems of Congolese refugees in Jyväskylä. I am aware that the interview will be tape recorded. I understand that my confidentiality will be maintained throughout this research. I am also aware that the information received will be published, but my name will not appear in results. I also understand that am free to deny giving the answers to some specific questions during interview. I understand that the recorded tapes will be erased afterward and am free to withdraw my participation at any time. I am aware also that the tape-recorded interview will not compromise my safety in any way.

Date and place.....

Participant

.....

Signature.....

Signature of student nurse

Patrick Ndayishimiye.....

William Nziza Nshongore.....