Barriers Faced by Refugees to Access Health Care Services in Finland

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Laurea University of Applied Sciences **Abstract**

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The main aim of the thesis was to identify various internal, structural, financial, and socio-cultural and communicational barriers faced by refugees in accessing health care services in Finland, and to propose suggestions to overcome those barriers. The thesis was a part of the Master's degree programme in Global Health and Crisis Management offered by Laurea University of Applied Sciences in Finland. The population on which the research was conducted were refugees in a reception center of South Finland. Ethical issues related to the thesis were evaluated by "The Human Sciences Ethics Committee of the Helsinki Region Universities of Applied Sciences". The data were collected after the ethical evaluation and permission from the reception center. The existing literature suggested the presence of barriers like lack of awareness, language, acculturation, scheduling conflicts, and long waiting lists. Inadequate cooperation at different levels, lack of will and means to cooperate, legal and economic barriers have also been reported in the past by different studies. Qualitative methods were used to conduct this thesis. The sample size was nine as it was the saturation point. Convenience sampling method was used in recruitment of participants and the data were analysed using deductive content analysis method. The data were collected by focused interviews, analysed and managed in a professional way using the ethical code of conduct.

This thesis found out that the internal barriers in health care in Finland for refugees were internal fear, refugees' own attitude, lack of knowledge of the complicated health care system, and mistrust in the beginning because of hard and bad experiences with health care professionals in other countries where they stayed as refugees before reaching Finland. The structural barriers faced by refugees while accessing health care in Finland were the long distance between hospitals and reception centers, long waiting times for appointments, scarcity of public transport in remote areas, and missing previous reports. The financial barriers in Finland faced by refugees were insufficient finances available for phone calls to be made for booking appointments when calls are long, and some financial difficulties in case they need to buy some medicines from their available monthly allowances. The communicational and socio- cultural barriers faced by refugees in Finland were the difficulty to understand the Finnish language, difficulty with interpreters, cultural differences, and lack of cultural competency in health care system.

Despite of the barriers faced by refugees in accessing the health care system in Finland, almost all the participants appreciated the health care system, and health care professionals in one way or the other. The suggestion given by the participants to reduce the barriers was creating a parallel health care system for refugees to have easy access and less waiting time. To reduce communicational barriers participants suggested providing information in more languages than Finnish and English. To reduce cultural barriers more culturally competent health care professionals were suggested. The distance between hospitals and reception centers should be smaller to reduce structural barriers.

Keywords: Refugees, Healthcare, Access, Barriers, Immigrants.

Contents

1 Introduction

The right of highest attainable standard of physical and mental health for all is established in the constitution of World Health Organization from 1948 stating that health is a fundamental right of every human being without distinction of race, religion, political belief, economics and social condition (World Health Organization (WHO) 2020). We live in a world where people from one nation are migrating to other nations to take refuge for the reason of war and unsafety in their own nations. In the process of this immigration as a refugee food, shelter and health are the basic needs which need to be met at nation where they escape for because of danger to their life in their own country. As health is considered as basic right of any individual by World Health Organization, so it is crucial to take care that basic need of health is met at all the points in foreign lands. World Health Organization states that health is fundamental to be attained for security of people depends upon the co-operation of states. (WHO 2020.)

In practice however, according to the European Union (EU) Agency for Fundamental Rights states that fundamental rights remain under threat in many Member States as such rights may routinely be denied, particularly at the stage at which asylum is determined (WHO 2018). Access within public health system depends upon particular status of individual refugee (WHO 2018). Increased migratory pressure in Europe posed additional challenges for health care providers for vulnerable groups like refugees (Chiarenza, Dauvrin, Chiesa, Battout, & Verrept 2019). When refugees apply for asylum, their presence in country becomes legal, as formal registration is done in the first receiving country. According to World Health Organization report (2018), refugees are 10% of the total population of Europe and one third of international migrants worldwide. Refugees formally owe protection, including access to health services, by their first country of registration for asylum (WHO 2018).

Access to health care varies across the WHO European region and within national boundaries. Universal right to health as a basic human right should not be compromised regardless of a person's administrative status. It has been ratified by the International Covenant on Economic, Social and Cultural Rights and the EU Charter of Fundamental Rights that laws and practices deviate from these obligations in some countries. Finland, under the refugee quota, accepts persons whom the "United Nations High Commissioner for Refugees" (UNHCR) has designated as refugees or other foreign nationals who are in need of international protection. (Report of Finland 2019). In Finland, asylum seekers are not granted the same entitlements for health services as the Finnish residents, but in general the Finnish legislation provides to asylum seekers a level of access to services comparable to most western European countries. The system for delivering these services is separate from the general public health care and

organized and funded by migration authorities. Asylum seeker's health care services are organized at the reception centers in Finland. They can undergo a health examination and the purpose of the health care services is to help them stay as healthy as possible, both physically and mentally, and prevent illness. (Finnish Immigration Services, 2020).

Social, medical and health services in Finland health rights are guaranteed by the public authorities as per the constitution of Finland. The health care system and social welfare comes under the municipality, which is financed by the government. Studies done in past about refugees and their health care access found out that refugees face barriers in accessing health care. According to Tuomisto, Tiitala, Keskimäki, and Helve (2019), refugees and asylum-seekers often encounter circumstances in which their health and well-being are compromised. Chuah, Tan, Yeo and Quigley (2018) state that the refugees do not receive the same health care services as are received by residents. Another study done by Shrestha (2017) about utilization of health services for refugees in Finland found out barriers to information and economic accessibility. Hence it is pertinent to know what kind of barriers they are facing in accessing health care services in Finland, so the proposed thesis was planned. The main aim of the thesis was to identify various internal, structural, financial, and socio-cultural and communication barriers faced by refugees in accessing health care services in Finland, and to propose the suggestions to overcome those barriers.

2 Basic concepts

According to Duzkoylu, Illksen & Cem (2017), hundreds and thousands of people have been forced to leave their homes and find refuge, medical, and social aid with ongoing civil wars in their home countries. When any person or family move to any other country for one or the other reason, all the health system is new for them in new country. If people are migrating for the purpose of job or work it cannot be that hard to get equipped with the knowledge about health system of the country, as it can be to a person who has moved to take refuge in the country. Lee, Sulaiman and Thompson (2013) states that many refugees come from the countries where concept of preventive care in health is unfamiliar and health care is provided when health problem progresses to serious stage. It is traumatic for any human being to leave his native country, when future to the new place is totally uncertain.

Refugees after leaving their own mother land face many mental and psychological traumas because of uncertainties in all the areas of their life. Food, shelter, and health are basic needs of human beings and refugees faces the barriers of language and translation issues in accessing quality health care (Green 2017). Health is fundamental right of all human beings universally as stated by World Health Organization and cannot be compromised at any cost irrespective of the place, time, and citizenship status (WHO 2018). According to Finnish

Institute for Health and Welfare (2020), refugees may have traumas as they might have encountered war, torture, violence, or their journey might have been dangerous and traumatizing. This fact makes it clear that their basic right of health is at the maximum stake in their period of time. Health care including all aspects like physical, and mental health really need to be taken care of. It is responsibility of governments to make it certain that basic need of health of their citizens are met and equally important is to know that the basic need of health is met for refugee in the country they are taking refuge.

As health professionals it is our duty to find out the facts about challenges or barriers refugee may face to avail the basic need of health. Duzkoylu et al. (2017) states that although refugees come from different countries, their collective experience allows suggestions to be made about healthcare needs, challenges, and outcome expectations. As it is said that charity begins at home, so to inquire the status of refugees in our own country can help us to understand the facts. Finding the barriers to access health care can be step forward to overcome those barriers and give an opportunity to refugees to avail the health services at the fullest. This thesis will play an important role to find out the barriers and suggestions to overcome those barriers. To have deeper insight, it is important to understand the basic concepts like barriers, refugees in Finland, health care in Finland, and existing studies putting light on the fact about barriers faces by refugees in Europe and whole world.

2.1 Barriers to health care

Barriers can be defined as obstacles or challenges which block the way of a process. Barrier is like a wall or fence between the flow or movement which is needed to meet some movement or criteria. While we talk about barriers in health care can be perceived as the challenges or problems faced by any person in getting the health care he is entitled to receive. Barrier or challenges can be visible or invisible. Barriers which are apparent like financial and structural barriers are visible barriers, on the other hand, internal barriers and cultural barriers are had to visualize and can be considered as invisible barriers. According to World Health Organization (2018), refugees lack financial protection and support for health which is a visible barrier.

Some barriers like attitude of any person for health system or facilities, own perception of the behaviour and understanding of the health system are hard to visualize but play crucial role as a challenge which hinders the reception of health care which any person should have received as a basic need. Refugees are considered as vulnerable population worldwide and they are subjected to poorer health outcomes because of financial and structural barriers faced by them in utilizing health care services (George, Daniels and Fioratou 2018).

In this thesis where barriers faced by refugees in accessing health care in Finland will be discovered, the barriers can be understood as the difficulties, restrictions, or hinderances faced by the refugees to access the health care in Finland. To have deeper insight into internal, structural, financial and socio-cultural and communication barriers faced by the refugees in health care service utilization, it is vital to understand the essence and significance of these challenges.

2.1.1 Internal barriers

Internal barriers can be implied as the challenges, which are not visible but are present. Internal barrier may include perception about the health care system, Lack of education, lack of health literacy and own perception of healthcare professional's attitudes due to previous bad experiences. According to Rink, Muttalib, Morantz, Chase and Cleveland (2020), health literacy is a barrier for refugees to comprehend the diagnosis, plan for the treatment and medical administration. Prior trauma and situation at the time of refuge can prevent refugees to utilize the health care facilities. Refugees many times reach to a country of refuge after travelling long journey through different countries. Bad experiences with the health care system, fears, and traumas within them make them reluctant to share everything about their health, which in turn becomes an internal barrier. According to Lawrence, Sheila, Brandstein, Terry and Linda (2003), disparity between health care giver and health care receiver becomes a barrier in health care system.

Low level of education increases the risk of low level of health literacy and can be further described as inability to read the posters, leaflets even in English language (George et al. 2018). Refugees although come to the new country, being born and brought up in their own country they have a set mind for the health professionals and their attitude. In some countries nursing profession is looked down and are thought of less equipped with the knowledge so, their own mind set becomes an internal barrier in accessing health care. Unfamiliarity and unawareness of how the health system works and how to navigate it blocks the way of receiving health care a person is entitled to have. Some refugees expressed feeling of stigmatized by the distinct identification and registration process required to access health care system. (Rink et al. 2017). Health literacy of any person is considered as the capacity to obtain, communicate, and understand the health information and services to make better health decisions (Alwan et al. 2020). If health information is present, but person cannot comprehend the health care information and the availability of health services in the health care system are not understood, how can the person avail the health care benefits provided in that country.

2.1.2 Structural barriers

Structural barriers refer to the barriers that are visible and significant. Some examples of structural barriers are availability and accessibility of health care, waiting time, transportation, location of the refugee centers in respect of the health care centers. How organized health care system is in the country for refugees determine the extent of structural barriers in accessing health care. Structural barriers are defined by availability of health care system and this barrier is found within or outside the health care facilities (Carrillo, Carillo, Perez and Salas-Lopez 2011). Refugees as a group of vulnerable population mostly live away from the residents of the country, which cause difficulties with the transport to reach desired health care centers (George et al. 2018). Infrastructure and transportation system of the country especially between refugee centers and health care centers plays a role in becoming a structural barrier. In case of illness even bus journey becomes a challenge to reach the health center.

Structural barriers can be independent or overlap with the financial barriers (George et al. 2018). Refugees reported that sometimes they go back and forth in the journey, but did not reach at health center in time, and challenge of inadequate transportation becomes a challenge (Alwan et al. 2020). Lack of medical records becomes a structural barrier for refugees to access health care (United Nations Children's Fund (UNICEF) 2017). Long waiting time make refugees frustrated, as they perceive their health need is not met at right time or late and sometimes end up deciding not to go for heath care center or book an appointment (Alwan et al. 2020). Some refugees feel that there are fewer diagnostic tests and prescription of medicines as compared to their own countries and they take is as if they are not taken care of appropriately (Alwan et al. 2020). Lack of interpreters and cultural mediators, long distance of secondary health care services from the camps can be considered as structural barriers, which were experienced by the refugees in Greece (Joseph et al.2020). Structural barriers encompass the availability of health care system for both external and internal factors to immediate heath care facility (George et al. 2018).

2.1.3 Financial barriers

Financial barriers can be considered as lack of health insurance, social benefits and unable to pay for some health procedures or care. Denial of some specific care and procedure plays the role of financial barriers (Rink et al 2017). As refugees are not entitled to have all the care which residents receive free of cost or some part paid by the social service department, so to pay in some cases becomes a challenge. A Caribbean mother as a refugee in Canada had to pay for her son's eye treatment the money which she had kept for her house rent (Rink et al. 2017). Financial barriers for refugees can be services for dental health also. One refugee in

Quebec was supported by social welfare but her 5-year-old son was not treated when had dental abscess as a policy dental services for refugees were not covered by social services at some point of time (Rink et al 2017). Money or finances prevent referral to specialized care and missed appointments for refugees. Little money can be big for refugees as in the state of refuge, they are not earning and becomes a challenge for them. According to Joseph et al. (2020), cost of medication for refugees has been a challenging issue in Greece, as some electronic prescription need a little money to be paid. This money is not significant or huge, but for refugees to spend this amount is hard too. According to Al- Rousan, Schwabkey, Jirmanus and Nelson 2018), barriers in access to medicine and other financial problems were reported by the Syrian refugees in Jordan.

2.1.4 Communicational and socio-cultural barriers

Communication and socio-cultural barriers can be language challenges faced by any person to understand, communicate and convey the message. Communication barriers results in miscommunication and in health care field it can be dangerous in respect of health of the health care receiver. A study done by Rink et al. (2017) explained this barrier very well as a mother came to the emergency department to seek health care for her son. She had to leave without getting care because she was unable to speak French language. According to George et al. (2018), communication barriers include use of medical jargon and language that the patient is unable to understand. Such incidences impact negatively the relationship between patient and health professional and resulting in consultation being misunderstood. People struggle to navigate the health care system because of limited language proficiency (Rink et al. 2017). Some refugees feel if they are deaf and dumb because of language barriers, and many feels isolated (Alwan et al. 2020).

Lack of language provision, lack of cultural competency, and lack of clear guidance make the health care utilization difficult for refugees (Humphris and Bradby 2017). Health care as a basic need of human beings require person to communicate many times with health professionals like booking an appointment, change in appointment and cancellation of some appointment. It is challenging to find interpreter every time and getting things explained with the help of interpreter too (Alwan et al. 2020). Situation becomes frustrated and person end up with the decision of not to access health care. Home remedies used by people in own county can serve as a cultural barrier in accessing health care too. In many cultures pain is taken lightly and treated at home with home remedies, which can lead to untreated sickness and serious sickness. According to Alwan et al. (2020), refugees from some countries treated their pain with the boiled rosemary and high blood pressure with garlic.

Cultural incompetency of health care workers is considered by the refugees in many countries (Au, Anadakumar, Pretson, Ray and Davis 2019). According to Wagner, Burke, Kuoch, Scully and Armeli (2013), refugees have health problems compounded by a lack of access to linguistic and culturally appropriate services. Existing health education material is sufficient for several different ethnic groups, but need is felt to change the approach to reach more ethnic groups and add new information as old pamphlets does not contain updated information (Palinkas, Pickwell, Brandstein, Clark and Hill. 2003). Interaction with the health care professionals while discussing medical history, symptoms, describing characteristics and duration of illness becomes daunting with limited language skills (Green 2017). Figure 1 explains different internal, structural barriers, financial barriers, socio- cultural and communication barriers faced by refugees when they access health care system in the country of refuge.

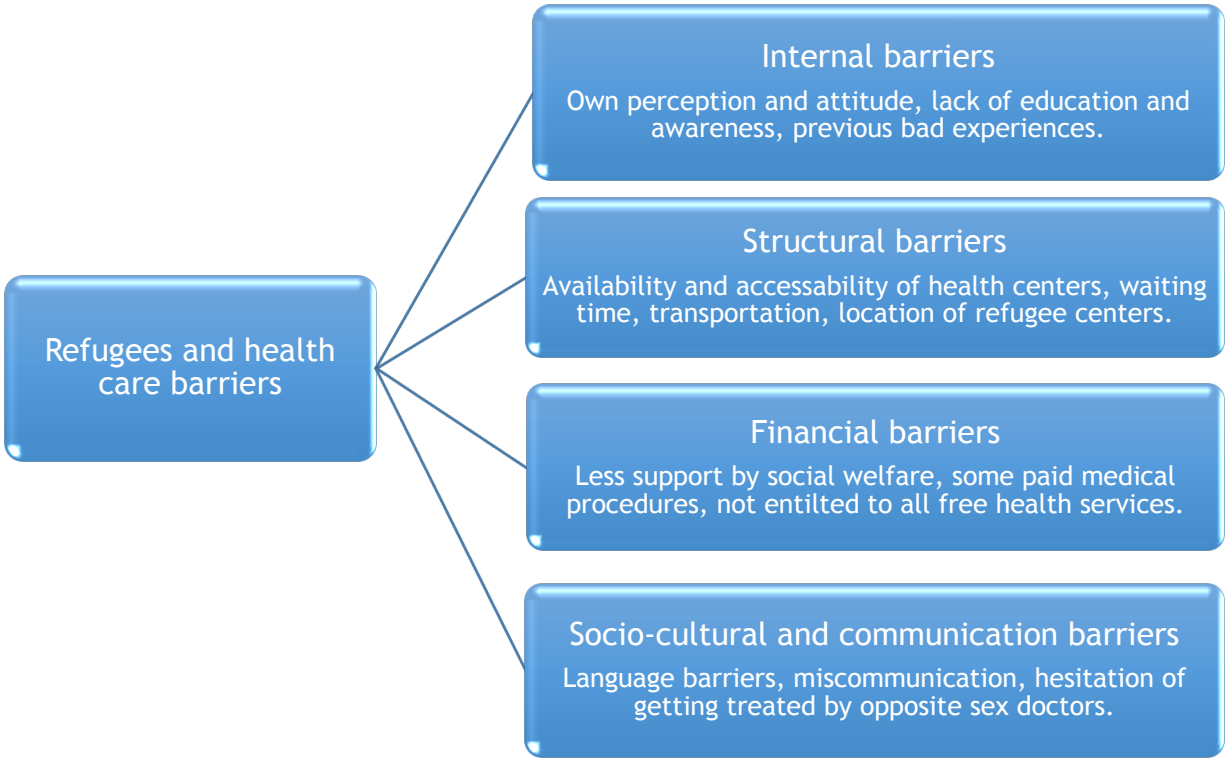

Figure 1: Refugees and various barriers faced by them in accessing health care per existed literature

2.2 Refugees and healthcare

Refugees can be considered as vulnerable population in any country subjected to poor health outcome. Reasons that make refuges vulnerable are their socio-economic status, health status, ethnicity, vulnerable to abuse (George et al. 2018). Refugees at the time of refugee

are in a state of recovering from the trauma they had in the past, which also make them vulnerable group. The term refugee applies to every person who, because of the serious events like external aggression, foreign denomination, or occupation disturbing public order in his residential region or country compels to leave the country to take refuge in some safer country disturbing his or her life (Elliott and Segal 2012). One person out of 10 in European region of World Health Organization is an international immigrant (WHO 2018). World Health Organization regional office for Europe has taken the responsibility of leading and assisting the sates which include 53 member states. Main focus is to illuminate the reasons, results, and response to the health need and problems faced by refugees and immigrants in their species region or country (WHO 2018). Refugees often experience little interaction with locals, so feel isolated making it difficult to practice the language makes it hard to be acquainted with the culture and health care system (Green 2017). Accessing quality and appropriate health care is critical but challenging for refugees.

According to Lamb and Smith (2002), six hundred thousand refuges have settled in Australia from the World War II and find many difficulties in accessing health care facilities at various stages of getting refuge. Health of refugees are influenced by many factors like bad transit experiences, previous traumas, poor living situations and make it complicated and complex for refugees to utilize health care (Alwan et al. 2020). People released from detention homes having temporary visas, and people waiting for the decisions about their status while applications are in process comes under refugees and experience persecution, psychological traumas, and difficult access to health care (Lamb and Smith 2002). While refugees formally owe protection by the country of refuge under international convention and these obligations formally grant access to health care services for refugees, in practice, these obligations are practically denied (Humphris and Bradby 2017). Table 1 gives the statistics given about refugees by UNHCR in 2020. According to UNHCR people who are in need of international protection includes prospective asylum-seekers, asylum- seekers, recognized refugees and persons with complementary, subsidiary and temporary form of protection, and others in refugees-like situation (UNHCR 2020).

According to The UN refugee agency (UNHCR 2020), statistics of 2020 explains that 67% of refugees comes from Syria, Venezuela, Afghanistan, South Sudan and Myanmar. Turkey hosted largest number of refugees which is 3.6 million. Germany hosted 1.1 million refugees in 2020. Statics also explains that 30-34 million out of 79.5 million forcibly displaced persons were children below 18 years of age, which comprises 38- 43 percent of refugees (UNHCR 2020). Figure 2 describes the classification of refugees which has been given by UN refugee agency in 2020. Real definitions of different type of refugees, collection of statistics regarding refugees, compiling the statistics and dissemination is challenging for the international agencies (UNHCR 2020).

Year	Number of refugees	Reason of refuge
At the mid of 2020	80 million	Forcibly displaced people worldwide.
At the end of 2019	45.7 million	Internally displaced people.
At the mid of 2020	26.3 million	Voluntarily took refuge.
At the mid of 202	4.2 million	Asylum seekers.
At the mid of 2020 in Venezuela	4.5 million	4.5 million Venezuelans left their country including 138,600 refugees,808,200 asylum seekers, and 3.6 million displaced abroad.

Table 1 : Statics of refugees given by the UN refugee agency (2020)

Refugees are always recognized as underserved population suffering with infectious diseases and mental health problems (Au et al. 2019). Their poor health status is associated with the pre arrival and post arrival factors like trauma in their country and in the journey, poor health care on their own country, and problems in utilizing appropriate health care (Au et al. 2019). Research done by UNICEF makes it clear that access to health care is restricted in most European countries and depends upon their status instead of their needs (UNICEF 2017). In their home countries because of uncertainty, abuse, threat to life, and poor health condition force them to leave their home country and come to Europe for refuge. Some of the refugees in some countries face barriers in accessing health care because of high stress, uncertain legal and economic status (UNICEF 2017). Delivery of health care to refugees in high -income countries can be visualized in three main themes, which are, the health care encounter, working with health care system, and asylum and resettlement (Au et al. 2019).

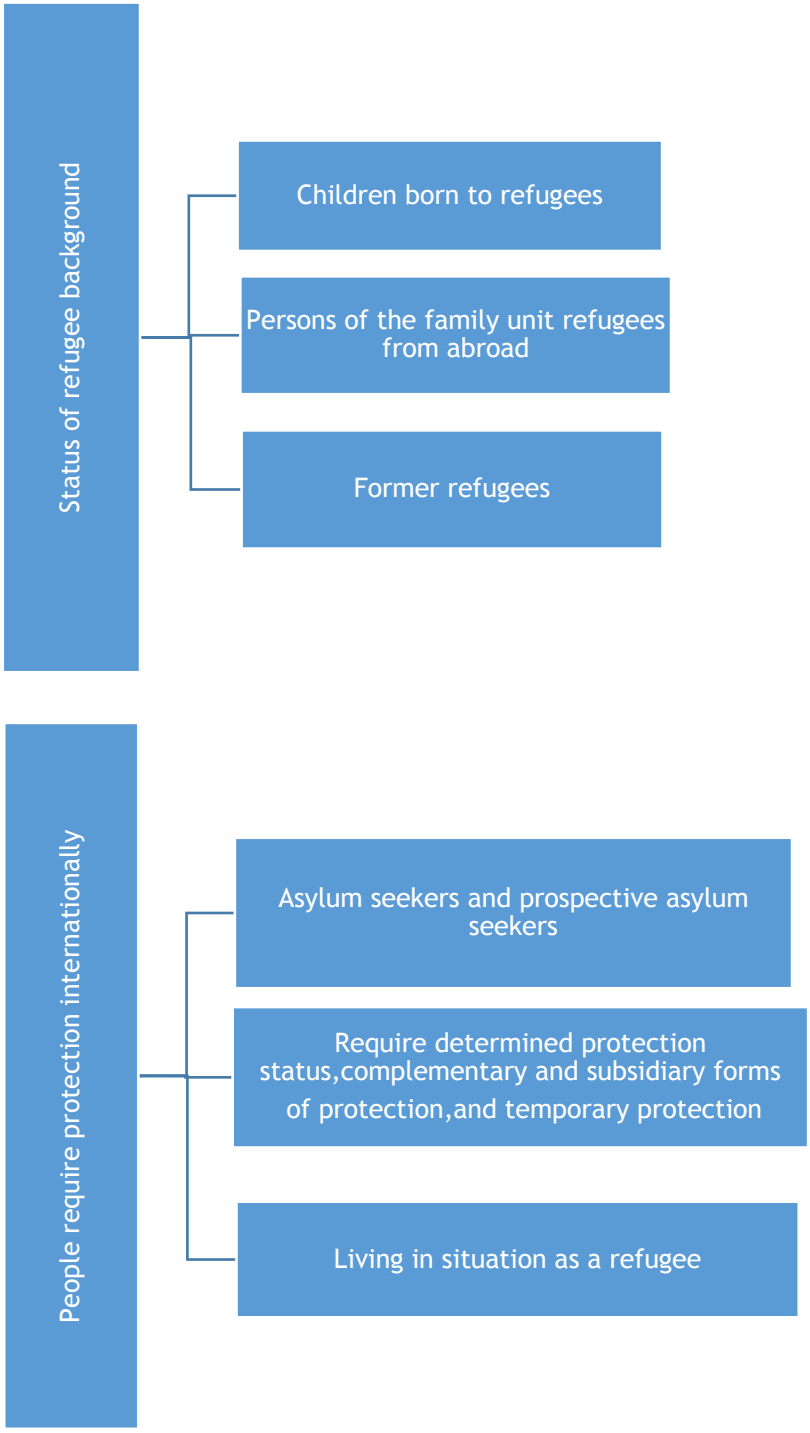

Figure 2: Classification of refugees by UN refugee agency (2020)

2.3 Refugees in Finland

According to Ministry of Internal affairs (2020), “A refugee is someone who has been granted asylum in one state or another. A person may receive refugee status if they arrive in Finland based on a proposal by the UNHCR with respect to Finland's refugee quota. “According to UN Refugee Agency (UNHCR 2019), “A refugee is someone who has been forced to flee his or her country because of persecution, war or violence. According to Finnish institute for health and welfare (2020), the refugee will be allocated to a municipality and considered as its resident with refugee status. This institute gives the definition of refugees as a person who has been granted asylum in Finland because they need protection for the reason of risk of persecution and threat to their security in their own home country. The definition of refugees has expanded and access in scope and complexity and so have the solution (Lahav 2016). The scale of challenges and problem including health care obliges the governments to address the realities.

A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. It is evident from the definitions that once they leave their country, they may not want to return back or are not in a position to return to their country of origin due to multiple fear factors. Once they enter a different country, they desire to stay in that country in the long run, hence will rely on that country’s resources for basic necessities such as food, shelter and health care. According to Ministry of the interior Finland (2020), “Finland is committed by international agreements to providing international protection to those in need.” Under international protection, people arriving from other countries may apply for asylums. If they fulfil the criteria, they can be granted asylums, and alternatively they may receive subsidiary protection in Finland. Refugee children in eight member states of the Europe, which includes Finland, Sweden and France have the same right to health care as children of that country. Undocumented migrant children are also legally entitled to emergency health care in aa 28 EU member states and Finland is one of them. (UNICEF 2017).

Tuomisto et al. (2019) state that over 2.2 million refugees were registered in European Union in 2015 and Finland received 4th highest number of refugees during mass migration of Europe in that year, which caused strain for reception system. Table 2 reflects the number of applications for protection to obtain refugee status in Finland. According to the table as number of refugees in Finland is significantly high, the study of health care available to this population and barriers faced by them is of utmost importance. Before discussing the available health care services and the challenges faced to access, it should be noted that health care services are accessible only to people with status of refugees. There are other existing categories of people that are not eligible to access health services. Finnish Immigration Services (2020) shared the statistics about refugees in Finland, which has been

shown in table 2. According to Health services in Finland (2020), a person in the application process of asylum seeker is not eligible to access health services. Someone who has obtained residence permit and right to municipality of residence can access health services.

Year	Number of Applicants
2015	33169
2016	4895
2017	5178
2018	4568
2019	4536

Table 2 : Statistics of refugees in Finland by Finnish Immigration Services (2020)

2.4 Health Care Services for refugees in Finland

Ministry of Internal affairs in Finland is responsible for the issues related to migration including refugees and asylum seekers. According to World Health Organization (2017), access to highest attainable standard of health care is a fundamental right of human beings and financial hardship should not be the obstacle to access health services. Everyone should be able to avail the services without discrimination based on religion, faith, race, gender, ethnicity etc. (WHO 2017). According to them, “the aim of health care in Finland is to maintain and improve people's health, wellbeing, work and functional capacity and social security, as well as to reduce health inequalities”. This ministry is responsible for formulating the health policies at a broader scale whereas the arrangement and funding of health care services falls under municipalities of Finland. Someone with a municipality of residence is eligible to avail services provided by them.

Health care services are categorized into two main categories, which are primary health care and specialized health care. Primary health care mainly falls under the jurisdiction of municipalities and are available at municipal health centers. System of delivering health care access to refugees is separate from the general public health care system and service level has been designed to receive low number of refugees. For refugees maternal and child health care is restricted, and mothers and children with uncertain resident status are not included in full range of antenatal, postnatal and paediatric care services. Seven EU states have no specific provision for maternity care for migrants and Finland is one of them. (UNICEF 2017).

According to Ministry of Social Affairs and Health of Finland (2017), primary health services include monitoring of the health of the population, promoting wellbeing and health, prevention, diagnosis, and treatment of diseases. Specialized health care services succeed primary health care services, require specialized doctors and are provided in hospitals. The patients cannot access specialized care in public health care system. Doctors examine the patient's condition and decide whether he/she needs this care. Apart from the health care services described above, private health services are available in Finland provided by private companies, independent practitioners and organizations. "Private healthcare companies must apply for a license for their operations from a Regional State Administrative Agency or the National Supervisory Authority for Welfare and Health (Valvira)". According to Tuomisto et al. (2019), asylum seeker in Finland is not granted the same entitlement for health as it is for residents, though Finnish legislation provides to refuges a level of access to services comparable to most western European countries. The Social Insurance Institution Kela which is the Finnish government agency that takes care of settling benefits under national social security programs reimburses the medical expenses made at private health care centers for eligible people only.

World Health Organization has also given a report for WHO European region regarding health of refugees, which states that public health should include refugees and migrants and there should noy be any area of public health where refugees should be excluded (WHO 2018). Finland follows those guidelines of World Health Organization too. This is first kind of report or guidelines given to work towards the development and promotion of refugee and migrant oriented health system in the European countries including Finland. World Health organization focuses on the fact to improve gap between planning and implementing the health policies in Europe including Finland (WHO 2018). Further actions are taken through collaboration of different agencies and countries of Europe to make it sure to respond to the challenges and health needs of the refugees. Some refugees come from the countries where communicable diseases are more common than in Finland. Refugees are offered opportunities to participate in communicable disease screening and vaccination. (Finnish Institute for Health and Welfare 2020).

According to Finnish Institute for Health and Welfare (2020), health promotion is a big challenge, and this question need to be addressed for health and welfare of refugees. This institute make it clear that they are entitled to urgent and necessary health care which include maternity care, sexual and reproductive health. Perceived and actual cost of health care of refugees makes the health care system complex and lead to limit the access of health care (Murray and Skull 2005). Though health care services are readily available to residents with municipality of residence status, people arriving as asylum seekers may face barriers to access these services or may be eligible to receive limited services. Any person arriving in Finland as asylum seeker is referred to and accommodated in the reception centers.

According to Finish Immigration Services (2020), there are many reception centers of different types and sizes in different parts of Finland. These centers are maintained by the State, municipalities and Finish Red Cross. While asylum seekers apply and wait for the decision to their application under process, they are entitled to basic statutory services available at these reception centers. These services include services such as housing, social services, reception allowance, spending allowance and health care. Apart from making a public health nurse available at these centers, they also purchase health care services from private sector or municipalities. The Social Insurance Institution in Finland is not responsible for cost associated with medical care provided to asylum seekers. (Health Care in Finland 2020). A person whose application is denied and does not receive residence status eventually loses the temporary protection and access to these services.

UNICEF (2017) demands EU member states including Finland to make sure that refugee children get access to health care and main guidelines are following.

1. Country or state has to make sure that health care professionals are aware of the rights of refugees about health care.
2. It is responsibility of the state to ensure that refugee children can access public health sector as in the same way as nationals have.
3. UNICEF demands the need of clear and direct wall between health care givers and immigration authorities.
4. Community leaders, counsellors should play important role to build trust of refugees, in giving needed information of the health care system and facilities available for the refugees.

2.5 Challenges faced by refugees to access health care in European countries

According to Kohlenberger, Buber-Ennser, Rengs, Leitner and Landesmann (2019), in most of the European countries, refugees continue to face challenges to access health care services such as structural, financial and socio-cultural barriers. Structural barriers include language barriers and lack of interpreters that lead to less usage of preventive health services by refugees. Financial barriers include less health facilities available for refugees and underfinanced health system, in Finland is not responsible for reimbursement to refugees. Socio cultural barriers include refugees not disclosing their mental health issues due to stigmatization. This also includes their hesitation to disclose their health issues and accessing them due to fear of deportation. As the data reflects in Table 2, 2015 was an exceptional year for Finland as number of applicants for international protection were enormous. The health care system meant for these people is not as substantial as the health care in general available for the residents. Humphries and Bradby (2017), while assessing the health care

status of refugees and asylum seekers in Europe found that legal, economic, cultural and language are the major which causes the declining health status of refugees.

A study was conducted by UNHCR (2011) on collecting data from refugee women to gather their opinions about challenges and barriers faced by them in Finland. The women participated in the study had concerns about lengthy process of asylum seeker's application. Also, some of them staying in reception centers situated in isolated areas felt not connected to the rest of the world. Their stay that could last up to a few years left them unfamiliar with Finland's various aspects and also led to fear and uncertainty about their fate and status in Finland. They also exhibited lack of understanding by reception center staff of their circumstances such as their situation in their own countries and its possible impact on these asylum seekers. Communication and translation problems were also mentioned among barriers. Lack of knowledge of Finish language and unavailability of interpreters was one of the biggest challenges to seek health care and mental health services. This led to delay in obtaining proper health care services. Occasionally their children were forced to act as interpreters that led to discomfort among women specially to discuss about their sexual and reproductive health issues. Their own children who had to interpret for them were not desired interpreters by these women for mental health issues too. They were unable to discuss personal health issues if their spouses were acting as interpreters. The women under study also expressed their concerns about lack of psychosocial support.

Another study by Kang, Tomkow and Farrington (2019) has identified psychosocial and mental illness as a significant health issue among people migrating to European countries. These problems become more prominent due to existing challenges such as cultural, religious and language barriers and are infuriated by receiving country's legal framework regarding status of migrants, bureaucratic, financial and structural problems. According to this study non-government and humanitarian agencies support activities such as communication and access to health services by asylum seekers. However, this limited support can be improved by better coordination among various medical and non-medical agencies involved. This study has further recommended better intersectoral and international collaboration to fulfils diverse health care needs of these migrants based on comprehensive approach. Since number of migrants in European countries are increasing every year, these countries should access their preparedness and capacity of health care system.

The study done by UNHCR (2011) on refugees and migrants was conducted in 15 EU countries to understand the health needs and barriers to health care. Refugees and health workers both participated in this study. The study emphasized that primary health care should have information about the health care needs of refugees. The participants also expressed the need to have adequate information about the rules and procedures in the reception centers. They further mentioned that since the previous health treatment received by them was not

recorded or was recorded only in the local language, there was lack of continuity in the health care received. Administrative problems such as lack of knowledge about how to activate their identity cards to receive the required medicines also hindered the access to health care services. Language and cultural barriers were identified as obstacles to access the health care services. Participants desired to have culturally sensitive and compassionate health care workers that they can trust. The authors of the study highlighted lack of finances and manpower as barriers to access health services. Study done by Leonen et al. (2017) stated that refugees face barriers like time pressure, cultural difference, and lack of continuity in care and they wished more information about health promotion aspects.

Tuomisto et al. (2019) traced that lack of will and means to cooperate, inadequate coordination at different levels are the major hurdles in accessing health care services by refugees in Finland. They proposed the abolish of parallel system of health care for refugees and integrate them with national health care system. Hahn et al. (2020) found that refugees in Germany are particularly affected by bureaucratic barriers, unfamiliarity with new health system and language. He suggested that country should address the needs of refugees at systematic and individual level. Kohlenberger et al. (2019) studied the barriers to health care services by refugees in Austria and found scheduling conflicts, long waiting lists, lack of knowledge about doctors and language as the major barriers faced by the refugees. It was suggested that by improving information flow about treatment and addressing language barriers, better health care services can be provided to refugees.

Communication and language barriers are very frequent because of the diverse population as a result of immigration (George et al. 2018). This study done by George et al. (2018) in Romania to find the barriers faced by the vulnerable group and found out that language barriers bring the health care givers and receivers at a difficult situation and hinder the delivery and access of health care. Some other communication problems included different level of education, lack of understanding of health professional about the situation and associated multifaceted needs. Cultural barriers were also addressed in this study which included cultural beliefs, religious beliefs, and discrimination received by the health care professionals based on the ethnicity. Cultural barriers also existed because of the unwillingness of the care receiver to access pertinent health care. Barriers in Romania has led to unmet medical needs and negative health outcomes. Participants came up with barriers like their own perception of all health care professionals because of some bad experiences.

According to UNICEF (2017), lack of health coverage, need of interpretation, and financial barriers are faced by the refugees in different countries of the Europe. According to Joseph et al. (2020), refugees in Greece face barriers like socio- cultural differences, understanding the Greece health care system, and changes to healthcare provision. The change in health care system for refugees is attached to the change in funds given by EU and economic crisis in

Greece (Joseph et al. 2020). Legal barriers, distance between health care center are refugee centers, complexity of access to secondary health care, long waiting time for secondary care appointments, language barriers, gender and cultural sensitivity of the care givers, and insufficient access to primary health care are the barriers which refugees face in Greece (Joseph et al. 2020). This study was done in Greece, which stated that most of the refugee centers are on islands and distance to primary health care and secondary health care are between one to two hours. Weak co-ordination between NGO's themselves and with international organization itself is a barrier for health care to refugees in Greece. Dental health services, mental health services, child health services, and vaccination programs have been reported with gaps in health care planned and received. (Joseph et al. 2020).

Refugees can have little interaction with the local people of the country, so they feel isolated and makes it hard to practice the local language and learn the differences in social interactions (Green 2017). Understanding directions to take medicine from pharmacist, calling clinics to make appointments are challenging for them because of the language. Although free German language courses are offered by the government, waiting list to get those courses are really long. (Green 2017). According to Lebano et al. (2020), Insufficient interpreters, lack of cultural mediators, communication and information barriers has been reported in many countries in Europe. This study after literature review of barriers in Europe found out barriers like transcultural competencies of health care givers in Italy, shortage of health professionals in islands, and lack of interpreters in emergency care department (Lebano et al. 2020).

Greece, Italy and Spain are entry points for refugees for entrance in Europe, and challenges in heath access for refugees, and challenges for health care givers to refugees are more extensive in these countries as compared to other countries. Countries like Greece, Spain and Italy receive enormous number of refugees as compared to other European countries and refugees move to other countries, so these countries are known as transfer countries also. Transfer countries face problems in providing health care to refugees because of problems like lack of money, less human resources, organizational malfunctioning, and poor coordination between the all the organizations involved in providing care to refugees. Problems faced by transfer countries make it clear how refugee are facing challenges in accessing health care when insufficient money and resources are provided for refugees. (Lebano et al. 2020).

2.6 Challenges faced by refugees in accessing heath care globally

As refugee face a lot of barriers in accessing health care in different European countries, they face barriers in other continents also. The refugee crises of this decade amount to an upcoming global challenge facing almost liberal democratic countries, pitting their

humanitarian norms against their survival and well-being (Lahav 2016). Right of health is a basic right of everyone globally and when governments are trying to the fullest that refugees should be given this right. It is a challenge on the part of health care givers and states that they impart this right without any barrier. Several studies have been conducted in various countries to assess the barriers faced by refugees. To have a better understanding on the given theme, a few of them have been reviewed and discussed below.

Chuah et al. (2018) examined the key health concerns and barriers to health care access among refugees in Malaysia and found that poor health literacy, lack of awareness, and language and cultural barriers were the main reasons for limited health access. It was suggested that health literacy and bridging language and cultural barriers can help the refugees in access to better health care. According to Duzkoylu et al. (2017), refugees in Turkey face sociocultural and economic barriers to health services. According to Lee et al. (2013), refugee women from 50 different countries which moved to Western Australia faced challenges and barriers to health related to accessibility of information on health as they lack knowledge about community health sources.

A study conducted by Asgary and Segar (2011) on refugees who came from African countries in United States and found out that language barrier was more for them those they do not understand Spanish. Interpreters for Spanish language were easy to get than other language. Social barrier faced by these refugees was in the way of difference in social life in their country and United States. Participants expressed the fear they have to be friendly with other people and share their feelings or heart. Baukje, Hamilton and Easley (2008) did a study to find out barriers in accessing primary care for refugees in Canada. This study concluded that health care utilization is low in first three months, though refugees arrive in the country with health deficit due to refugee camp living condition and need special care and protection in new country. A study done in Australia by Murray and Skull (2005) found out that refuges face a number of barriers in accessing health care like language difficulties, cultural difference, legal barrier, and less health work force. Participants in this study also expressed that low awareness of health-related issues and policies about health of refugees become a barrier for them. Refugees face financial barriers which influence their health and access to health care in different ways (Murray and Skull 2005).

Drummond, Mizan, Brocx and Wright (2011) conducted a research to find out the barriers in accessing health care which West African refugee women were facing in Western Australia. Interpersonal issues like shame or embarrassment about the health condition, fear of family and friends thinking about the problem, fear of being judged by the health care providers were the barriers reported. These barriers were reported high in more educated women than less educated women. Fear of hospitalisation and logistical problems like whom to approach for help and long time in getting help were another form of barriers for refugees. According

to Elwell, Junker, Sillau and Aagaard 2014), linguistic barriers, lack of transportation and mistrust of physicians served as barriers in utilization of health care for refugees. This study was conducted in Denver which also reported that previous bad experience of refugees with health care givers also became a barrier in accessing health care. Lack of health insurance and employment served as financial barriers and were reported by some refugees.

According to Rink et al. (2017), extent of the language barrier can be understood as many of the health care receiver return back without getting health care. A south Asian mother struggled to understand the receptionist and could not book an appointment as the language was French. In another incident it was found out that family does not know their rights to see the doctor as they do not understand from the internet. Another important aspect which this study brought into the light was the stigma of refugees while they have to show the documents of refugees while accessing health care. They look down on themselves and feel embarrassed while using the papers. Refugees feel frustrated and humiliated when they ask about some questions about paying money for some procedures, which used to be free of charge some months back but paid now because of change in health policies. Financial constraints are almost universal for the people who are refugees but have not yet found employment (Lamb and Smith 2002).

Another barrier reported to access health care was fear in refugees who experience torture in which health care giver has been participated (Lamb and Smith 2002). This study was done in Australia and found out different financial, Structural and internal barriers. Newly arrived refugees might have multiple health problems and meeting special multiple needs may be challenging for the health care givers. Mistrust or lack of trust can prevent some refugees to access health care though this mistrust might be the result of abuse by the government authorities dealing with their paperwork (Lamb and Smith 2002). Another important barrier found out was language barrier resulting into miscommunication, misdiagnosis, and lack of appropriate treatment and follow up.

In Australia also refugees are not eligible to commonwealth- funded health services. Specific group of refugees like old age refugees and second-generation refugees need specific health care which is not developed yet (Lamb and Smith 2002). Lack of familiarity with the health system of country of refuge, and lack of awareness of health facilities available for refugees are crucial barriers in refugees of Australia. Although refugees get assistance in communication from interpreters, family, and friends while they access health care, spoken and written language were experienced as barriers across many aspects of care. In some cases, if same interpreter assists in communication, it is beneficial but change in interpreter has been perceived as difficulty or challenge in communication. (Cheng, Drillich and Schattner 2015).

A study done by Alwan et al. (2020) in United States about role of beliefs, behaviour and perception of refugees as barriers in utilization of health care. This study found out that difficulty in understanding the health care system leads to impact on health seeking behaviour and further act as barrier in utilization of health care (Alwan et al. 2020). Refugee who goes to primary health centers and find difficulty in understanding of language, feel stigmatized and become reluctant to seek further health care. Health barriers for refugees include time pressure, linguistic differences, cultural differences, and continuity of care (Alwan et al. 2020). This study also found out that missed medical appointments of refugees lead to late diagnosis and treatment. Finding new appointments times after it was missed was a challenge according to the refugees. Some of the appointments were reported missed because of the language barriers, difficulty in understanding of the health care system.

Some of the people while trying to confirm the appointment or booking an appointment was not understood and resulted into missed appointment because of the instructions on the phone in another language (Rink et al. 2020). Refugees struggle to access the health care system because of unfamiliarity with the system of country of refugee because of the fact that sharing of the information is needed which is not done effectively (Au et al. 2019). According to Au et al. (2019), in their report when they did a systematic review of refugee's perception about health care system about the experience of refugees in Australia, found out that trust in health care professionals and their privacy becomes barriers for them in utilizing health care facilities. Physical health of refugees is seriously compromised on the basis of barriers like less lack of finances, lack of transport (Wagner, Burke, Kuoch and Scully 2013). A study done by Al-Rousan et al. (2018) found out the cost of health care as a barrier in access to health care for Syrian refugees in Jordan.

3 Development of thesis

In the development settings purpose and objectives of the thesis, methodological solutions, sample size, population, selection criteria, data collection, data management, and data management have been documented.

3.1 Purpose and objectives

Purpose of the thesis was to identify various Internal, structural, financial, communicational and socio-cultural barriers faced by refugees in accessing health care services in Finland, and to propose the suggestions to overcome those barriers. The thesis had following objectives.

1. To explore the refugee's access to health care.
2. To identify the frequent internal, structural, financial and socio-cultural and communication barriers faced by the refugees in health care service utilization.

3. To make suggestions to overcome barriers based on findings of the study.

3.2 Methodological solutions

According to Kothari and Garg (2014), research method is the way to systematically solve the research problem. Methodology can also be defined as the steps, procedures, and strategies for gathering and analysing data in a research investigation (Polit and Beck 2004). This research used qualitative method comprised of focused interviews to address research question. According to Creswell (2009), qualitative research involves emerging question and procedures, and data typically is collected in the participant's setting, and data analysis inductively building from particulars to general themes, and researcher make interpretations of the meaning of the data. Qualitative research is the investigation of phenomena, typically in an in- depth and holistic fashion, through the collection of rich narrative materials using a flexible research design (Polit and Beck 2004). Qualitative research methodology is crucial method which can be used when researcher plans to ascertain and theorize prominent problems (Jamshed 2014)

As data was collected from refugees, it was good to have the understanding that refugees often have acute mental health problems, trauma symptoms, notably depression, traumatic migration experiences (Langlois, Haines, Tomson and Ghaffar 2017). They might have faced fear of being persecuted for reason of race, religion or ethnicity in their own country, and this fear may be with them after leaving their own country too. Refugees are considered a vulnerable population as they experience vulnerability, marginalization especially women, children and elderly which affect their health (Langlois et al. 2017). This study method allowed analysis of barriers faced to access health care for refugees. Focused interviews were conducted to get insight to the problem and answer research question. Interview is a common method used to collect data in qualitative research (Jamshed 2014). Interview is a method of data collection in which one person means an interviewer asks questions of another person, which is a respondent (Polite and Beck 2004). Focused interview is a loosely structured interview in which an interviewer guides the respondent through a set of questions using a topic guide (Polit and Beck 2004). Focused interview was used as a tool with some open-ended questions which are in the appendices (Appendix 1).

Process of the focused interview has been explained in data collection documentation. Length of one interview was 30 to 45 minutes. Focused interview with key questions (Appendix 1) helped the interview or participant in the process of interview to express their expressions, experiences and feelings. Questions acts as an anchor also for the researcher to get out the depth of the challenge or barrier. Sometimes participants know that there is a barrier or challenge but hard to express without questions. Focused interview with some questions helps the participants to keep going and express deeply. Focused interviews are the interviews,

where interviewer is well aware of the respondent and in case there is deviation from the subject, interviewer refocuses the respondent towards the key subject (Jamshed 2014). Questions about the method to reduce expressed barriers were also included in the interviews.

3.3 Population, sample size, and sample selection criteria

A population is the entire aggregation of cases in which a research is interested (Polit and Beck 2004). As this research was about finding barriers for refugees in accessing health care in Finland, so population was refuges in the reception centers of South Finland. According to Polit and Beck (2004), sample is the process of selecting a portion of the population to represent the entire population. Sample is very important subset or elements of population selected for data collection and sample size is the number of elements selected for the study. Selecting appropriate sample size is crucial step, insufficient sample size may result in unreliable answers and excessive sample size wastes resources and potentials (Guo, Logan, Glueck and Muller, 2013). In this research sample size was nine informants and they were refugees who were able to speak and understand English. Sample included both men and women participants. For sample selection convenience sampling method was used for final selection of data, as participants who participated in the study were the most convenient available. According to Polit and Beck (2004), convenience sampling entails using the most convenient available people as study participants.

After the review and permission by The Human Sciences Ethics Committee of the Helsinki Region Universities of Applied Sciences data collection was started. Reception centers had the protocol about any research taking place in the reception center which was followed. According to the protocol of the reception center information sheet of the research (Appendix 3) and recruitment invitation form (Appendix 4) was needed to put the notice board of the reception center, so that participants could know about the research and volunteer participants could contact the researcher. As at the time of research COVID-19 pandemic was at its peak, so no visitors were allowed to go to the reception center. The researcher could not go to the reception center personally to put the needed documents on the notice board. Information sheet about information of the project (Appendix 3) and recruitment invitation for the interview (Appendix 4) was e-mailed to the concerned person of the reception center as guided by the reception center and they put them on the notice board.

Researcher waited for two weeks for volunteer participants to contact the researcher, but no participant contacted. COVID-19 pandemic situation brought the research at a halt, as people were afraid of moving much in this situation of pandemic. As advised by the reception center a poster (Appendix 5) was prepared to draw attention of people about the research, keeping in mind that poster might make the research clear just in one look. Poster was emailed to

reception center, which was put on their notice board for a week, but nobody contacted. Eventually many English-speaking participants were approached by the manager of the reception center personally by sending them messages informing about the ongoing research. Almost 15 participants approached researcher through phone and e-mail. Purpose of the research and procedure of participation was explained to volunteer participants. Information sheet about information of the project (Appendix 3) and participants consent form (Appendix 2) were sent online to the participants. Researcher was able to conduct nine in depth interviews, as nine was the saturation point.

3.4 Collection of data

Data is a piece of information obtained in the course of a research project and data collection is gathering of that information while addressing research problem (Polit and Beck 2004). In research project collected data is analysed and managed. As collection of data is gathering information to address a research problem and some tool is needed to collect the information. The questions in the interview in this research were focused to find the answer for research questions and served as a guide to move in interview. These questions while collecting data helped the process of interview and researcher to explore the issues leading to answer research question. It allowed the flexibility for participants to describe or elaborate the information, opinions, or views. Focused interviews are in depth interviews where questions serve the purpose of guide to keep the interview focused on the desired line of action (Jamshed 2014). Interview method is used to explore the views, experiences, beliefs and motivation of individual participants (Gill, Stewart, Treasure and Chadwick 2008).

Consent form included the consent of participants to participate in the research and record their interviews, (Appendix 2). Interviews helped participants to share their views, experiences, and opinions about the internal, structural, financial, socio-cultural and communication barriers faced by them in accessing health care. Suggestions and opinions about overcoming the barriers were also asked from the participants. The consent forms were linked with an alpha-numeric code. The master list of names and alpha-numeric codes, consent forms were kept securely in the file in laptop of the researcher. Laptop was secured with double codes. The list was revealed not to anyone but the researcher of the study. All the document related to this research were kept safely in the personal laptop of the researcher in a file with password which will be in double protection as laptop has a password too. As study is qualitative and data was collected through interview, the data collected through interviews was kept confidential. Interviews were recorded in audio form and not any video recording of the interview was done. Interview was recorded on the personal laptop of the researcher. Data of the interview was kept securely in the personal laptop of the researcher in a file with the password. Personal laptop has one password too so file will be secured in double password.

Focused interviews were conducted with the participants online by telephone. Focused interview with some open-ended questions were followed which are in the appendices (Appendix 1). While designing an interview it is important to aske question which might yield much information and address and aim at answering research questions (Gill et al.2008). Sample size in the research was nine and sample was consisted of refugees who were able to speak and understand English. As all the documents like recruitment information, information sheet, and consent form be in English and participants understood purpose of the study their rights and data management clearly. One interview took place from 30 to 45 minutes. Process of focused interviews, management of collected data, safety of data and data destruction has been documented in data management section and also in data management plan in appendices (Appendix 3). Data saturation method was used in this process. According to Beck and Polit and Beck (2004) qualitative research sampling decisions are guided by the data itself. High quality data is demonstrated as accurate and valid, so decision of data saturation is done if themes and categories in the data become repetitive and redundant

3.5 Analysis of data

Analysis of collected data was done by qualitative content analysis. Content analysis has been described as indigenous to communication research because it analyses data collected in messages and communications versus observable events or individual properties (Renz, Carrington and Badger 2014). Qualitative content analysis is a research approach for description and interpretation of textual data using the systematic process of coding (Elo and Kyngäs 2007). Content analysis in this research followed deductive content analysis. Deductive content analysis leads from specific from general statement (Elo and Kyngäs 2007). Data analysis were comprised of preparatory phase, organization phase, and reporting phase. In preparatory phase collected data in the form of interviews were listened repeatedly to find out the major themes or types of barriers expressed by the participants. After obtaining the sense of whole, unit of analysis were decided. Data was categorized and subcategorized to answer the research question. Content analysis is done to organize and elicit meaning from the data collected and to draw realistic conclusions from it (Bengtsson 2016).

In organization phase data was organized in which data was categorized and systematic coding was done. Content analysis is a systematic coding and categorizing approach used for exploring large number of textual information unobtrusively to determine the pattern of words used in their frequency, their relationships, and the structure and discourses of communication (Vaismoradi, Turunen and Bondas 2013). Content analyses go with the process of coding and creating categories, grouping codes under higher order heading, formulating a general description of the research topic through generating categories and subcategories as abstracting (Elo and Kyngäs 2007). Table 3 explains the process and steps taken during analysis of data. Coding units were identified to answer the research questions.

Phase of data analysis	Process and outcome of the phase
Preparatory phase	This phase included familiarizing with the data by repeatedly listening to the interviews. This phase included analysis of conversation by decontextualization and recontextualization.
Organization phase	Coding units were identified to answer the research questions. Data was analysed using the coding units. Using coding units, the data was divided into headings, subheadings and subcategories. Data analysed was compiled in a systematic way to answer the research question.
Reporting phase	Analysed and systematically compiled data has been documented.

Table 3: Data analysis process (Elo and Kyngäs 2007).

Using those coding units data was categorized in headings, subheadings. To explain the data analysis process in simple way is that research question was given codes. All the barriers were given different codes. During the analysis of data those codes were recognized. Every code was divided into themes and subthemes (Headings and subheadings). Recognition of themes and subthemes under a specific code were written in the form of headings and subheadings during reporting phase. Final step of data analysis was reporting the data has been documented in the form of findings.

3.6 Data management plan

According to General data Protection Regulation or GDPR (2016) Personal data "is any information that relates to an identified or identifiable living individual. Different pieces of information, which collected together can lead to the identification of a particular person, also constitute personal data." For the research studies, researchers identify the data by replacing any personal information/data with codes such as alpha numeric codes. If this data could be used to again reidentify a person that will also fall under the category of personal data. In order to protect the privacy, the data should be coded or encrypted in a way that is irreversible and cannot be reused to identify the person. Some examples of personal data include the name, surname, phone number, email id, home address, an identification card number, date of birth.

General data protection regulation (GDPR) provides with the regulations of the European parliament and of the council given in 2016 for the protection with regard to the processing of personal data and on the free movement of such data. Office of the data protection Ombudsman (2020) states “Everyone has the right to the protection of personal data concerning him or her. Data protection is a fundamental right that safeguards the rights and freedoms of data subjects when personal data is processed”. According to General Data Protection Regulation (GDPR 2016) data is “considered personal under the existing legislation include name, address, IP address, photos, biometric and genetic data.

Information collected gets lost, stolen or otherwise released into the hands of people who were never intended to see it and those people often have malicious intent. Under the terms of GDPR, not only do organizations have to ensure that personal data is gathered legally and under strict conditions, but those who collect and manage it are obliged to protect it from misuse and exploitation, as well as to respect the rights of data owners - or face penalties for not doing so”. According to GDPR data processing means operation or set of operations such as collection, storage, transmission, destruction, and dissemination of personal data. As in research data is collected and restriction of processing is crucial step as makes it clear that stored personal will not be processed in future.

Data management plan in this thesis has also been explained in appendices (Appendix 3). Data management plan in this research was according to guidelines of European Union General Data Protection Regulation (679/2016) using appropriate method. All the principles related to personal data processing were observed during the research. Data was processed lawfully, fairly and in transparent manner. Information of any kind which was stated in the research was not collected. Data was collected without any external assistance. Data was collected solely for the purpose of this thesis and will not be used in any form after the completion of this study. The research findings will not be commercialized and will be used for the purpose of thesis work only, however the findings may be used to recommend further research. Researcher has followed Personal Data Act and sensitive information such as religion, race, ethnic group was not collected from the participants (ARENE 2017).

Participants were provided with participants information sheet (Appendix 3) to make it sure that participants understand the purpose of the study and data management plan. No other personal data as defined by European Union General Data Protection Regulation (679/2016) was collected except for names that are required on the consent form (Appendix 2) and recording of the voice in the interviews. As the name of the participant appeared on the consent form; the consent forms were linked with an alpha-numeric code. The master list of names and alpha-numeric codes, consent forms were kept securely. The list was not revealed to anyone but researcher. Any soft copy or any document related to this research was kept

safely in the personal laptop of the researcher in a file with password which were in double protection as laptop has a password too.

As study is qualitative and data was collected through interview, the data collected through interviews was kept confidential. Interviews were recorded in audio form and not any video recording of the interview was done. Interviews were recorded on personal laptop and recorded data has been kept under double lock. Data of the interview will be kept securely in the personal laptop of the researcher in a file with the password. Personal laptop has one password too so file will be secured in double password. Within this thesis, personal data was processed according to the European Union General Data Protection Regulation (679/2016) and current national regulation. All the interview responses recorded will be deleted permanently in 6 months times after publication of thesis. Electronic files and every data related to research project will be deleted completely from the laptop in 6 months after the publication of thesis is complete to have protection against unlawful processing, and against accidental loss, damage or destruction.

4 Results

Research question which was needed to answer was the internal, structural, financial, communication and socio- cultural barriers faced by refugees while they access the health care in Finland. Focused interview comprised of open-ended questions gave the direction to get answer for the research question. Almost every participant appreciated the health care system of Finland in one way or the other. Main barriers after analysis of data were internal fear, own attitude of refugees, lack of knowledge of complicated health care system, mistrust if their problem will be solved or not, long distance between hospital and reception centers, long waiting time for appointments, less public transportation in remote areas, missing previous reports, less finances, difficulty with Finnish language, and difficulties with the interpreters, and lack of cultural competency in health care system. Participants gave their suggestions also to reduce or overcome barriers. Table 4 describes types of barriers refugees face in Finland while they access health care.

4.1 Internal barriers

Internal barriers as explained in this thesis were perceived as invisible barriers, which cannot be seen by the health professionals unless they are asked about or expressed by the refugees. Internal barriers faced by refugees in accessing health care in Finland were found out as their internal fear to access health care, their attitude towards the health care system of Finland, and lack of knowledge of health care system in Finland

Type of Barrier	People face in Finland to access health care
Internal barriers	Fear of sharing all the problems, Fear of wrong diagnosis or big health problem, Fear of not understood by health professionals. Negative attitude toward their health and health care givers. Lack of knowledge of health care system.
Structural barriers	Long distance between hospital and reception center. Difficulty with transport system. Long waiting time for doctor's appointment. Missing previous medical reports.
Financial barriers	Difficulty in paying transport cost. Avoiding calls for making appointments as it takes a lot of time. Difficulty in paying for medicines, if sometimes need to pay.
Communicational and cultural barriers	Not satisfied with some interpreters, Need of a particular interpreter with native language though of the same country speaking national language. Treating minor problems itself till the situation worsen. Difficulty in understanding and communicating in Finnish

Table 4 : Barriers to health care for refugees in Finland

4.1.1 Internal fear

Many refugees have the fear in their heart after going through hard journeying and situations that their life will never be settled, or their problems will never be solved. Out of the fear in their heart they conceal their problem rather than revealing it. Hard experiences with health professionals in other countries of refuge helps to develop the attitude that health issues of their life will perhaps never be resolved. Many health issues are the result of the torture, and bad experiences in some countries too while travelling to Finland. One participant and her 12 years old son was suffering from depression because of the torture and difficulties in other countries of refuge, before they reached Finland. Their attitude that even if they tell everything, there is nobody on the earth who can resolve it completely make them reluctant to access health care.

One of the big fears in many refugees is about deportation to their own country. Some participants out of fear does not tell the truth about their health conditions. One participant shared about a refugee, who was suffering from epilepsy in his home country. Out of fear he did not reveal this fact to the health care professionals and was not treated and eventually died. Other participants shared about some ladies living in reception center do not want to reveal everything about the health issues of their children, fearing that if authorities will come to know the whole truth, their children will be taken away from them. One of the participants was living under fear of deportation and was not concerned about health issues.

Many participants had travelled through a lot of countries before reaching Finland. The experience they had with health care professionals in other countries made them fearful about telling their health condition to health care givers in Finland too. One participant shared that she and her children had not been treated even as human beings in some of the countries. Stigma of being mocked by health professionals about their health condition also make them reluctant to access health care facilities available for them. This stigma is a result of bad experience with the health professionals in other countries of refuge while travelling to Finland. Fear of bigger diseases made them reluctant to reach health care facilities. One participant went to the hospital, some tests were taken, and he was suspected having AIDS. He became so afraid of the test he did not visit hospital again, though the results were negative. Opinion of one of the participants about his health follows.

> I am only waiting for my papers as my brother was deported to his home country. I am not concerned about anything else.

4.1.2 Internal attitude and mistrust

Own attitude of the refugee is a barrier to access health care in Finland. Most of the participants experienced Finnish health care system lengthy and complicated one. In their own countries on being sick they straight away go to the doctor's clinic or hospital. All the tests are done, and they get medicine, which is simple and short process. Refugees in Finland think that process of being diagnosed is really complex and lengthy. They become hesitant to access health care thinking it will take a long of time to reach a doctor. Some of the refugees have their mind set that eventually they will leave Finland to settle in some big country. Such refugees do not share their whole health issues openly. Refugees have to book appointments, which itself is with waiting time before they can see a doctor. Blood tests and other tests are at different place at different time periods. Before getting a proper diagnosis and treatment they have to go through a long-complicated process, so they think it is better now to access health care with so many challenges. Many do not want to reveal all the health problems in the beginning, as they have this attitude that if they will share their problems, it will not be kept confidential. Some of the shared statement has been documented here.

> In my country when we go to doctor straight when we have any health issues tests are done and, in the hospital, we get medicine from pharmacy. Whole process is so simple and pharmacy being in the hospital is of great help.
>
> In our country we have stigma not to share whole of being mocked of for our health conditions and it takes time to understand that in Finland everything is kept confidential.
>
> It is hard to trust health professional in the beginning because of the experience with health professionals in other countries of refuge.

4.1.3 Lack of knowledge

Refugees feel lack of knowledge and awareness of health system as a barrier. As the health system is new for them, it becomes hard for them to understand and access the health care facilities though available for them. Refugees are tried to provide with the information of the health care system and facilities they can avail, but to get fully equipped with the system and facilities is hard in the beginning. This has been perceived as barrier in accessing health care. Some expressions of the participants were as follows.

> I feel I do not have enough knowledge to understand the health system of Finland. In my country I was used to the health system of my country. Here everything was new to me. It took me some time to understand the system, and I believe to understand fully it will take more time.
>
> First time I went for health care, and I met a nurse. I was sent back again with the appointment of nurse again. she saw if I really need a doctor and then she booked my appointment. For me it was challenging and new for me that appointment of doctor takes a while.
>
> Pharmacies are far away here in Finland in my country we have pharmacies inside the hospital. This new health care system of Finland was new for me and because of lack of knowledge about health care system I got challenges to access health care.
>
> In my country I was familiar with the place and doctor's clinic. Here everything was new for me, and I felt I do not have any knowledge of health care system and facilities in Finland.

4.2 Structural barriers

Structural barriers are the barriers, which are visible and easy to identify as the term itself makes it clear. Structural barriers were obvious for refugees they expressed that long distance between reception centers, and hospitals is challenging to access health care for them. Difficulty to reach the right place with right buses with new language was challenging for them. In remote areas hospitals are really far away from reception centers, which has been perceived as a structural barrier by refugees. There is long waiting time before they reach a doctor for their health issues which refugees expressed a big barrier. When they leave their home country for their life and sometimes travel a lot of countries before reaching

Finland, so they do not have the record of their health problems and documents related to health. Missing previous reports has been perceived as a challenge to continue health care in Finland.

4.2.1 Long distance with to travel and different doctors in different appointments

Almost all of the participants shared that distance between reception center, and hospitals is long. With unfamiliar language and new transport system it is a challenge to reach at right place after taking right bus in right direction. Reaching the hospital was even difficult for some of the participants. One of the participants gave birth to her female child here who experienced that distance between reception center, and hospital was too much. She had to walk and take bus and train before she reached to the hospital. One participant who had also stayed in remote reception center in north Finland for some time, shared his experience about less transport available in that area. According to him interval in buses time was 3 hrs. If one bus is at 4pm next will come at 7 pm and there is difficulty as waiting time after the doctor's appointment can be 2 hrs. Sometimes to reach in time for the appointment person reaches 2 hrs ahead of the appointment time, as there is no option to reach too early than missing the appointment.

One another barrier faced by refugees in accessing health care in Finland expressed was different doctors at different appointments with same health problem. They expressed that if same doctor treats for same problem every time, it becomes easy. Sometimes some doctors understand thing very easily and next time that doctor is changed. While getting health care one of the important components is understanding between patient and doctor which takes some time. After being comfortable with one doctor, in next appointment doctor is changed as it is hard when every time doctor is different. Some expressions of the participants were as follows.

> In our countries it is easy to be treated by the same doctor all the time. Here in Finland treatment is done by different doctors. In one appointment we are seen by one doctor, and second time when we go for the same problem, doctor is changed. It is difficult to cope up with this situation. If all the time for one health issue we are treated by the same doctor, is helpful and comfortable for us.
>
> Most of the hospital is very far from the reception center and for a new person to reach there is a challenge.

4.2.2 Difficulty with the transport and long waiting time

It is easy for anybody to reach a place when he or she is familiar with the transport system and area. Refugees go to information office in reception center to understand the geographical area and mode of transport to reach hospital. Refugees take it as a structural barrier in access to health care. Taking one wrong bus sometimes miss their appointment. In

Finland with same number buses travel in two directions. Taking one bus with same number but travelling in opposite direction from the destination can lead to missing appointments. Waiting time to book an appointment has been perceived as a big challenge by most of the refugees. Refugees have to wait for long time when they want to book an appointment for the doctor. It takes from weeks to months sometimes and participant sees it as a big challenge. Some participants shared their opinion as following.

> I went to the information to understand the route to the hospital, but I took one bus to opposite direction instead of the direction of the hospital, so I missed my appointment with the doctor.
>
> In our country, if we have any health problem we can straightaway go to doctor's clinic or hospital and get the medicine and all laboratory tests done. In Finland for a simple treatment, we need to wait for the appointment of doctor which has long waiting time. Whole process of booking an appointment, getting the laboratory tests done, and getting medicines from the doctor is so lengthy. I fear if my problem worsens within this waiting time.
>
> When we call for appointment after waiting for long phone is picked up and we are told that that they will call us back and sometimes call comes next day.

4.2.3 Missing previous reports

Missing previous reports have been found out a barrier for refugees in getting access to health care in Finland. Refugees leave their countries out of fear and treat to their lives, and nobody brings papers of doctors from their home country with them. Some refugees have travelled a lot of countries before reaching to Finland. It is hard to save the papers and reports when people are migrating from one country to other for better life. After they get refuge, they get it hard to get connected to the doctors or health care givers in the country of origin. One of the participants shared that this is even risky to connect to the people back home to get previous reports. Though refugees are taken good care of in Finland, but missing previous reports is a challenge. Without papers refugees does not about the status of the vaccination of their children, previous medicines they used to have if they are under some treatment. One participant expressed his view follows.

> My brother had severe problem with his teeth. His teeth needed braces and dental health is really expensive also. Doctors needed previous report of my brother. We could not contact doctor in our own country. Eventually with great difficulty and long waiting time my brother was treated.

4.3 Financial barriers faced by refugees to access health care in Finland

In Finland not much financial barrier has been reported by refugees. If some appointment has been booked and same day a lot of people are supposed to go to hospital, conveyance is provided by the reception center. Bus ticket is provided also when appointment is booked. For some check-up if somebody just wants to go without appointment, they need to pay for the bus ticket. Most of the participants shared those medicines are provided free of charge

except one participant, who had to buy the medicine and she perceived it as a big financial challenge.

According to participants bus ticket is really expensive in Finland. When appointment is booked refugees are paid for the ticket but when they want to go to the hospital for some reason or check-up, they have to pay the bus ticket on their own from the money which they get from the government per month. Spending bus tickets from that money, which are expensive are really challenging for them as they feel that allowance money is too small to spend on bus tickets and medicines. For making an appointment, participants have to make calls which are lengthy leads to higher phone bills and to manage phone bills with monthly allowance is a challenge. Refugees experiences long calls as a barrier in health care. When they call for making appointments, on the first place they have to wait a lot on the phone and if call is transferred to appropriate department again, they have to wait for long time till their call is answered. Sometimes even after a long call they do not get appointment. One participant shares her experience as follows.

> I am afraid of making calls to the hospital as calls takes a lot of time and bill piles up. To make an appointment I have to put credits in my phone. All the time making an appointment means very long calls and they are really expensive. I do not work and only have the money, which is given. Many times, one call is not sufficient for making an appointment. you can be on hold for an hour and then health workers get back to you another day, as it would not be possible to solve the matter same day.
>
> We get free medicines, but once I had to pay for some medicine and spending money from my monthly allowance was not easy for me. I have to take care of lot of things with that little money.

4.4 Communicational and socio-cultural barriers

In communicational and socio- cultural barriers participants shared the problems like difficulty with Finnish language and with the interpreters. Refugees in Finland come from different cultural background and face challenges like less culturally competent health care professionals.

4.4.1 Language barriers

Although information the participants get is in English, but hundred percent information is not in English. Some people do really want to know and are desperate, so they post their documents or reports on Facebook, so that somebody will guide, which is not a safe way to get the help. In hospital language on the sign boards is Finnish. It is hard to have I interpreter all the time with you at every moment so reaching at the right place within the hospital is a challenge for some the refugees.

People who are not able to understand the language, to book an appointment for the doctor is a challenge too. They need an interpreter even to book an appointment and booking an appointment through interpreter is a challenging process. If any person who understands the language spoken it is easy to book an appointment than for the person, who books an appointment using interpreter. One of the participants shared experience of her neighbour who was speaking French. According to the participant "if that French speaking refugee has even small problem, no one will understand at the reception center. Always she needs an interpreter for everything and for every small problem she faces." Some others expressed as follows.

> Because of my illiteracy to Finnish language after reaching hospital I reached at wrong place in the hospital. I was guided to the right place of my appointment afterwards.
>
> Language is a barrier while we travel to the hospital using transportation.

4.4.2 Difficulties with the interpreters

Refugees in Finland face problems with the interpreters or interpretation on way or the other. Participants shared other people's experience too. Sometimes the interpreters speak same language as that of refugees, but they cannot understand what the person is trying to say. One of participant shared experience of his friend who requested for the change of interpreter. Interpreter was from the neighbouring country of his country of origin but could speak language of his country. Interpreter was not able to interpret what refugee was speaking, so interpreter was changed for him. Difference in accent of the participant while speaking language was a barrier to understand for the interpreters. One participant shared that it is hard to express the same expressions of the person while an interpreter is used. If someone understand the language in which problem is shared is better than understanding the problem through an interpreter.

Participants shared that expressing your own thoughts sometimes does not reach to the receiver in the same way as it is expressed if an interpreter is used. Interpreter cannot express the issue the same way you are telling. Efficiency of the interpreter also matters in health care. Sometimes interpreter for your language might not be expert in Finnish language, so interpretation depends on the fact that how efficient that interpreter is in Finnish. Some language has many dialects for one word and to express those dialects in Finnish is not possible, as in Finnish language there may not be an appropriate word for the translation. Interpreter may try his or her best but difference in dialects of these two languages becomes a barrier.

Some refugees need interpreter for booking the appointment with the doctor. They have to call to the interpreter, who call on their behalf and take the appointment for them. It is a

barrier too as if person in problem call for the appointment directly differs from somebody calling on their behalf. It might be more time consuming, and some information about the person might be missing while taking the appointment as interpreter might not know hundred percent about the health issues. In emergency situation sometimes it is hard to get the interpreter of the language of the refugees. One participant shared about one of his friends, who was unable to speak English and national language of his country. He could speak only regional language and in case of emergency, it took some time to get regional language speaker interpreter. In some languages there are words, which are not possible to translate in Finnish or it can be explained like this that some words in some languages does not have a correct exact word in Finnish, so it becomes a challenge to explain to the health professionals about the situation exactly. The following are some of the experiences of the participants they shared for themselves or for their fellow refugees.

> I needed interpreter so that my English could be understood as I have accent while speaking my English being my African background, but interpreter was not able to understand the situation and I believe it would have not been conveyed the way I expressed.
>
> He had to change the interpreter, as interpreter provided to him in the hospital was from his neighbouring country. Though she knew his language but was unable to understand and interpret.
>
> I had pain in my private parts while I had urine infection. It was difficult for me to explain to my female interpreter, if it would have been male interpreter, it would have been easy for me.

4.4.3 Cultural barriers

Refugees need interpreters for their health problems to be conveyed to the health workers. In some cultures, men do not want to share any health problem related to reproductive system with female and vice versa. If interpreter or doctor is female and men had some reproductive system health issues, they feel it difficult to tell it openly. In the same way, women with reproductive health problem take it as a barrier if they have to share it with male doctor or to share it with male interpreter for them. One of the participants felt a barrier of unavailability of herbs in Finland, which she used to take for small sicknesses like stomach-ache or headache and shared the views.

> If we have small headaches, we boil some herbs and use them, which is really effective. Now when I am in Finland, a lot of snow is there, and herbs are not there. I am not sure when snow will be melted away, if we can get some herbs in summer.

Some participants shared that in our country or culture we take little pain not seriously. He had headache and he tried to treat it at home, but after some days he had to book an appointment and get treated. Self-treatment at home in some cultures becomes barrier in accessing health care services for refugees too.

One participant shared that child are born here at the time of refuge; it is hard to get the same care for the children as in her own country. Some opinions have been stated in next lines.

> In my country we circumcise the male child and female child, how can we get the same care here. I am not feeling good because in our culture we pierce the ears of the female child at the time of birth, which is not possible here." She further added "She has given birth to female child here who was not circumcised, and ears were not pierced, and such things could have happened in her own country.
>
> I tried to treat my headache at home but when I could not be healed eventually, I have to take the appointment for the doctor.
>
> Culture in Finland is different. People are open and broad minded here. In my country with male problems, we go to male doctors. Here sometimes we have to share our issues to female doctor. Sometimes we are provided with female interpreters who translate our problem to a male doctor which is hard.

4.5 Positive experience of refugees about Finnish health system

Though refugees face a lot of barriers in accessing health care services in Finland, almost all the participants appreciated health care system and health care professionals in one way or the other. Some of the comments about health care system which refugees appreciated were as follows.

> I really appreciate the way I and my children have been treated in Finland. I feel as if I am a human being, as in Greece and Italy I was not treated like human beings.
>
> I was advised to tell health care givers even if I have small pain and not to conceal it, and to be honest it was really taken care of.
>
> I had some psychological issues and in my own country there is stigma to reveal mental health issues in front of the society and health care givers, here in Finland I was not stigmatized to share my mental health issues as I was never looked down.
>
> Not only prevention and treatment of health problems is taken care of, but health is promoted by providing the facility of gym.
>
> I never faced any problem in accessing health care in Finland.
>
> To overcome communication barriers in accessing health care we are provided with the Finnish language classes (which participants were attending online at the time of the study because of COVID-19 situation).
>
> I am not fearful that health professional will share my information with third party.
>
> I liked the system of confidentiality in Finland about the health issues.
>
> Nurses and doctors are really understanding and empathetic and try to solve every issue they can solve.

> Health care system in Finland is better than my country, in my own country for some health issues we cannot talk openly, but here we are encouraged to share everything openly and nobody look down on us.
>
> Finland government and health professionals try to take care of mental health by involving refugees in the festivals of Finland (mid-summer day, Christmas etc.) like providing special food and cakes etc.
>
> Finnish health system is the one of the best health systems, where we get basic health screening free of charge when we reach Finland.
>
> In health screening one of the refugees was diagnosed with the tuberculosis, he was treated completely free of charge where he was provided with conveyance to take him from the reception center and drop him back.
>
> When any health problem is shared with the health professionals, they try their best to solve the health issues.
>
> My interpreter was good, he gave me her phone number so whenever I had to book an appointment for my health issues, I was able to take it through interpreter and it was easy for me.
>
> Diagnosis and treatment are done not in a hurry but done after every test is completed, which makes it best health care system.

4.6 Suggestions to reduce or overcome barriers

This thesis was involved with the finding suggestions or opinions from the participants about better health care to refugees where they will face less barriers or problems in accessing health care facilities in Finland. In Finland there is not any parallel health care system for refugees, but they are getting care by the same system of health care which is for the residents. As refugees face barriers like, long waiting time for the appointment of doctors, different doctors for different appointments, long distance between hospitals and reception centers, it was suggested that there should be a parallel health care system for refugees. If there will be a parallel health care system long waiting time will be reduced as hospital will be only for refugees. With different or parallel health care system there might be a possibility that one particular patient will be treated by the same doctor in his appointments. As suggested if hospitals for refugees will be different and will be only for refugees, there is possibility to have hospital near refugee centers, and structural barriers like difficulty with the transport and long distance can be reduced. Though it might not be easy to have a parallel health care system for refugees now, as it can impose financial and workforce challenge for the government but can be given a thought of doing in some years.

Internal barriers like internal fear, negative attitude and lack of knowledge can be reduced by counselling and health education conducting health seminars or health education programs imparting knowledge about health care system. To reduce communication barriers refugees are provided with the language classes. Some efforts to have health leaflets in some other languages along with English might reduce communication barriers for new refugees, as these

barriers reduces with the time by learning Finnish language. To reduce cultural barriers health workers can be imparted with more education courses focusing cultural competence health care. More steps can be taken to consider the fact that refugees should have equal health care as the residents are getting. European Union need to improve equity of access to health care services, provide free vaccination in Europe for prevention and promotion of health (Marques 2012). Some of the participants shared their suggestions are as follows.

> It would be good if we get all the information at least in English instead of Finnish.
>
> It is good to have information is other languages also like French as a lot of people speak French now.
>
> It is good if there are hospitals are near to the reception centers, or there are more hospitals to overcome structural barriers.
>
> Appointments should not be with long waiting time, so that process of diagnosis and treatment is not so time consuming.
>
> Health workers should be more equipped with the cultural competence care.
>
> Hospitals for refugees should be at less distance from reception centers.
>
> It is good if same doctor treats same problem or health issues.
>
> It is better if refugees have different hospital only for refugees to ensure continuity and easy access.

5 Discussion, conclusions and reflections

We live in this era of time where people migrate from their native land because of war and unsafety in their own country to some other country for shelter and safety. In this migratory process as they migrate to take refugee they are entitled as refugees in the country. Their basic need like food, shelter and health becomes the responsibility of the country where they take refuge. According to World Health Organization (2020) health should be considered as a fundamental right of every human being irrespective of sex, age, ethnicity, religion, political belief and social condition. According to World Health organization report (2018) refugees are 10% of the total population of Europe and one third of international migrants worldwide (WHO 2018). Immigration in the form of refugees has impose a great challenge on health care system of the country where refuge has been taken. Refugees may face some challenges in availing health care available for them because of some barriers.

European Union (EU) Agency for Fundamental Rights states that fundamental rights remain under threat in many Member States as such rights may routinely be denied, particularly at the stage at which asylum is determined (WHO 2018). Proposed thesis tried to find out the

internal, structural, financial, communication and socio- cultural barriers faced by refugees in accessing health care in Finland. After analysis of collected data, it was found out that internal barriers in accessing health care in Finland for refugees were internal fear, own attitude of refugees, lack of knowledge of complicated health care system, and mistrust in the beginning because of hard and bad experiences with health care professionals in other countries where they were for refuge before reaching to Finland.

Structural barriers faced by refugees while accessing health care in Finland after analysis of data came up like long distance between hospital and reception centers, long waiting time for appointments, less public transportation in remote areas, and missing previous reports. This thesis found out financial barriers like less finances for phone calls to be made for booking appointments where calls are long, and some financial difficulties in case they need to buy some medicines from their low monthly allowances. The communicational and socio-cultural barriers, which were found after the analysis, were the difficulty to understand the Finnish language, difficulties with the interpreters and the lack of cultural competency in the health care system. Participants gave their suggestions also to reduce or overcome barriers. Earlier studies in the past in different countries have also found out similar type of barriers within Europe and internationally. Areas of further development have been recognized during this thesis and surely, they can be considered in future for the benefits of refugees and health care professionals. Results and already existed literature has been discussed in conclusion section

In the beginning of this thesis process already existed barriers were studied. A lot of studies have been done on challenges faced by refugees in utilizing health care services globally. After analysis the data and finding barriers in Finland it has been compared with the previous findings with same barriers as in thesis in hand. This thesis found out internal barriers like different fears of refugees, their own attitude, and lack of knowledge of health care system. Though previous studies found some other internal barriers also but hereby studies with similar internal barriers have been discussed. According to Marques (2012), many refugees feel it unsafe to seek medical help in the fear of deportation, so they do not obtain primary health care, and eventually children, and pregnant women suffer much. Lack of familiarity and navigation to health care system is a barrier for refugees in Canada (Gabriel, Morgan-Jonker, Phung, Barrios and Kaczorowski 2011). According to Marques (2012), lack of knowledge on the part of refugees for their rights for health facilities blocks the access to health care.

System of health care is complex and hard for refugees to understand, so lack of awareness limits abilities to refugees to understand the circumstances of their care and eventually it is a barrier to the provision of health care to refugees (Antonipillai, Bauman, Hunter, Wahoush and Shea 2017). Limited health care literacy of refugees makes it difficult for them to utilize

health care services which are meant for them in European countries (Cheng et al. 2015). According to Chiarenza et al. (2019), refugees does have the knowledge of entitlement and availability of services available for them and they suffer from poor access to health care in Europe. Refugees lack information on available health services and facilities and face difficulties in navigating health care services (Chuah et al. 2018). Negative health care experiences in other countries of refuge impact health care access for refugees in a negative way (Elwell et al. 2014). Lack of awareness of refuges regarding the availability of care for them and lack of understanding in policies related to health, limit their accessibility to health care services (Antonipillai et al. 2017).

This thesis found out barriers in finances and structural barriers like difficulty in making calls for appointments as it piles up phone bills, difficulty in paying for medicines, long distance between hospitals and reception centers, long waiting time, missing previous reports, and difficulty with transport. Previous studies with similar barriers are discussed here. Excessive waiting time may affect care seekers especially those who are in social and financial distress Carillo et al. 2011). Refugees described six months waiting time even to see a primary care physician and according to refugees it was extremely long time (Lee 2016). Long waiting time for the appointment can be considered as late availability of health care and health care system availability is a structural barrier. In the areas of islands, reception centers are located far away from the hospitals and refugees have to travel a long distance to reach hospital, and difficulty with local language make it more difficult for refugees (Joseph et al. 2018). According to Carillo et al. (20111), difficulty with the transportation attributes to the barrier in access to health care for refugees in Canada (Gabriel et al. 2011). Many refugees face barriers to timely access for appointments to health care centers (Lee 2016).

Barrier to health care access include transportation, cost and knowledge (Wagner et al. 2013). Lack of transportation and mistrust on doctors serve as barrier in accessing health care services for refugees (Elwell et al. 2014). Lack of education, health literacy, mistrust, and fear of vulnerable population of refugees acts as challenged in accessing health care (Sian et al. 2018). Lack of familiarity with the health care system of country of refuge is barrier for utilization of health care services (Hahn et al. 2020). Long waiting time in receiving secondary health care brings frustration to refugees and become barriers in accessing health care (Joseph et al. 2020). According to kang et al. (2019), lack of knowledge about eligibility for care and lack of regulations comes in the way of refugees while they try to access health care facilities. Lack of transportation from camp to nearby clinics makes it hard for refugees to access health care (Al-Rousan et al. 2018). Access to treatment such as waiting in queue, transportation or mistrust, and uncertainty has been reported by refugees in accessing health care in Finland (Shrestha 2017). Refugees face a number of barriers like language difficulties, financial needs, cultural differences, and low awareness of health issues (Murray and Skull 2005).

According to Lee (2016), refugees when call to hospital for appointment, phone is hanged up for long time, after long interval phone is picked up by next concerned person and again it is hanged up and before booking an appointment the phone call takes a long. To pay the bills is a stress for refugees, government covers only essential and emergency care and even reimbursement of the payment takes a lot of time (Baukje, Hamilton and Easley 2008). Refugees in Europe are not entitled to have full coverage to health care access, and it is a big challenge for the prevention and promotion of health care to refugees (Marques 2012). Barrier to access health care for refugees include financial cost of care place on them (Antonpillai et al. 2017). Insufficient government funds, insufficient income is included in financial barriers faced by refugees when we talk about health care facilities. Difficulty in paying for transport cost and dental treatment has been perceived as barriers by refugees (Kang et al. 2019).

Lack of information regarding health facilities, language barriers, and lack of finances have been reported by refugees as barriers faced while they want to access health care (Rink et al. 2017). According to Alwan et al. (2020), long waiting time, inadequate transportation, missed appointments, and translation services are profound barriers faced by refugees in the country of refuge. Lack of professional interpretation during health care and of cultural competencies in health care system serves the purpose of obstacles for refugees (Asgary and Segar 2011). Accessing appropriate and quality health care is critical among refugees because of linguistic barriers which comes in the way while interacting with health care professionals (Green 2017).

According to Au et al. (2019), the refugees struggle with health services accessibilities due to unfamiliarity with health care system. Lack of knowledge, lack of financial resources, and language barriers are significant obstacles that prevent refugees from accessing health care services (Marques et al. 2012). Main encountered barriers in accessing health care for refugees are linguistic and cultural differences, and lack of continuity in care (Loenen et al. 2017). Lack of competency of language and cultural competency to navigate health care system makes refuges difficult to access health care (Lebano et al. 2020). Practical barriers for refugees in accessing health care are inadequate information and awareness, insufficient financial means, restricted access to transport, culturally insensitive care, and inadequacy on the part of interpreters (Langlois et al 2017). Language proficiency and communication through interpreters brings hurdles for refugees in accessing health care services (Lamb and smith 2002).

Communication and socio-cultural barriers found out by this thesis were difficulty with the language, difficulty with interpreters, and difference in culture. Many studies in the past have also found similar results. Language is a barrier to health care access with low English language proficiency related to worse health (Wagner et al. 2013). Health care services are

not culturally appropriate, and refugees consider it as a barrier in accessing health care (Wagner et al.2013). Lack of cultural meditation services are barriers for refugees in access to health care system in Finland (Chiarenza et al. 2019). Difficulty in understanding language has been perceived as a barrier by Canadian refugees (Gabriel et al.2011).

Refugees struggle with the access to health care system of the country of refuge because of the cultural differences (Cheng et al. 2015). A study done by Lee (2016) also reported that refugees want to take traditional treatment of herbs is preferred by the refugees. Same study found out that refugees tried to bring herbs which were thrown out at the airport, though some managed to bring and get small sicknesses treated. Language and communication difficulties are key barriers for refugees to health care services in the country of refuge (Chuah et al. 2018). Linguistic barriers decrease health care access for refugees (Elwell et al. 2014). According to Duzkoylu et al. (2017), Although translators are there to translate for the refugees in each department of the hospital and camps, it is still challenging for refugees to explain their problems and medical history properly. According to Green (2017), refugees face language difficulties concerning making call to make appointments and understanding instructions from the pharmacist. Linguistic and cultural translation including health advocacy for refugees is crucial for facilitating health care (Humphris and Bradby 2017).

5.1 Assessment of the development settings

Outcome of any research defines the effectiveness in terms of answered research questions. This thesis has come up with significance barriers faced by refugees in Finland in accessing health care and got the answers to the purpose and objectives of the research. The way any qualitative research is reported makes its trustworthiness and effectiveness clear. When evaluation of any research is done it is considered If statement of the question is clear and the way it succeeded in findings answer to the research question. In this thesis the research question has been stated with clarity and reporting the findings aims at answering research question. Credibility is one of the tools used for assessing the credit worthiness of any study. Credibility refers to the confidence in the truth of data and interpretation of them (Polit and Beck 2004). Data was collected and interpreted with truthfulness without tampering to any fact related to barriers in health care and positive experiences provided by the participants.

According to Polit and Beck (2004), transferability refers essentially to the extent to which the findings can be transferred. Finding of the thesis has been transferred to the thesis writing with transparency and to the full extent as expressed or given by the participants related to barriers and positive experiences. Qualitative research is a mean to describe, and interpret experience, opinions, and views, which are not possible to give in numbers and tables and it is crucial to impart the result without being biased and being tempered to the viewers (Nowell, Norris, White and Moules 2017). In any research it is responsibility of the

researcher to report analysis research that aims to create sensitive, insightful, rich and trustworthy research findings (Nowell et al. 2017). Data was analysed with honesty and is recorded with precise and transparent manner to ensure the trustworthiness of the thesis. When data analysis process is recorded in detail explaining all the steps and analysis process is clear to the audience evaluation trustworthiness of the study is not difficult (Nowell et al. 2017). Every step and tool of data collection and analysis is documented in detail to make the thesis consistent and understandable to the audience.

Outcome is in the form of thesis, so thesis writing is the final step of performance and can also be stated as reporting qualitative research. The way the thesis is written clarifies itself about the research so thesis in hand is divided into various chapters like Introduction to the topic, basic concepts, research methods, discussion and results. Abstract, research question, sampling strategy, geographical background has been described while reporting. While reporting data analysis has been justified theoretically and themes after qualitative data collection are answering research question. In qualitative research there are interviews, diaries, and opinions of the people and any missing step may alter the effectiveness of reporting (O'Brien, Harris, Beckman, Reddy and Cook 2014). Every step taken during collection of data and analysis of data has been documented. While reporting any research documentation of ethical review board, consent of participants, security issues, and confidentiality must be reported, which was kept in consideration in this thesis.

5.2 Areas of further development

Though in this thesis many themes about barriers faced by refugees in accessing health care in Finland have come out after analysing the data, more research can be done on bigger scale. This thesis mainly dealt with the barriers and only asked suggestion to reduce those barriers. In future wide research can be done on finding the ways to reduce or eliminate the barriers. It is clear that refugees have challenges but the way some participants shared the challenges along with appreciation of health care workers more research is needed to be done on the barriers faced by health care workers while they provide care to refugees. If these challenges need to be reduced or eliminated it is good to know the part of health care givers and their efforts. It might be challenging with health care givers to impart health care to vulnerable people from different culture. Even some research including interpreters and other organizations can be conducted if this issue needs to be solved in respect of benefit for refugees, health care givers, government agencies and NGOs working for the betterment of health of refugees. Researcher have understood while interviewing the participants that it is really hard and stressful on the part of nurses and other health care professionals, Research is needed to be carried out on these aspects.

As at the time of research because of COVID- 19, researcher could not meet participants personally, in future when situation become normal, more research using different methods like focus group, where researcher can meet participants face to face. More evaluation can be done in planning and implementation of health care services for refugees, so research can be carried out on the area of evaluating health care given to refugees. There is limited research in remote areas and further evidence is needed in these settings (Au et al. 2019). In future research can be carried out collecting data from more reception centers like of North, East, and West Finland.

Saturation point in this research was nine, as data was collected from South Finland, so in future some researcher might find some more or different barriers and different positive experiences if data will be collected all over Finland. Same research can be done using some different methodology and approach to address the same issue too. Structural barrier like availability of health care system can lead to decreased care, late presentation, decreased prevention, and disparities of health outcome. In future research can be done to improve promotion of health and prevention of diseases in refugees. Some research can even be done to improve methods of cultural competency for health care givers. According to Duzkoylu et al. (2017), health education programs can help to adapt cultural differences. Much of the challenge in health care for refugees is related to communication. Working with professional interpreters requires training and experience on the part of the clinician (Hauck, Corr, Lewis and Norman 2012). There is need of research on transcultural health care in Finland. According to Hahn, Steinhäuser & Goetz (2020), sociocultural approach in health care system can ensure equity in health care as cultural competence education should be increased.

5.3 Funding

Funding means funds, finances or any compensation in any form that can be means of facilitating progress in study. This thesis has not received any type of funds or finances from any organization or institution. Participants were not compensated in cash or kind to provide data. Participants who were interested in the project came up to participate in the research to share their experience in barriers they are facing in accessing the health care in Finland.

5.4 Ethical issues and privacy protection issues of research

Ethical conduct is instrumental in any research work from the beginning of the research work. As most of the research involves literature review and data collection from human beings, complete understanding of ethics is important for the researcher. Ethics in research is a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal, and social obligations to the study participants (Polit & Beck 2004). In order to avoid any intellectual property issues or plagiarism a researcher must

provide complete citation for the ideas/wordings taken from the external sources. Researcher should not change or manipulate the data after it is collected, these actions are inappropriate and unethical. A researcher should not fill up any incomplete surveys or questions. Collecting data from participants without their knowledge is unethical such as observing people and their behaviours etc. A researcher has ethical and moral obligations toward persons who are objects of the research, the research community, the professional field, stakeholders of the research, and society among others.

As the thesis was conducted as a part of Master's program in Laurea University of applied sciences of Finland, appropriate guidelines given by Finnish national board of research integrity were followed. While interacting with humans to collect data anonymity and confidentiality was maintained. As guided by Finnish National Board on Research Integrity (TENK) thesis process was honest, open, reliable and visible (ARENE 2017). Causing harm and risk to the participants was avoided. Plagiarism was avoided in research process, so any statement taken from other studies in theoretical background has been written with clear reference. Ethical issues were kept in consideration while reporting the research. Research plan was submitted to The Human Sciences Ethics Committee of the Helsinki Region Universities of Applied Sciences. While submitting thesis plan, participant information sheet, and consent form template of participants were attached. The research process started only after receiving approval from The Human Sciences Ethics Committee of the Helsinki Region Universities of Applied Sciences.

Since the research requires to collect primary data from refugees in South Finland, the approval from reception center was obtained. After the positive review from "The Human Sciences Ethics Committee of the Helsinki Region Universities of Applied Sciences". permission from reception center of Helsinki to conduct research was applied. After the evaluation permission was granted from reception center to collect data. As the protocol of reception center is that information sheet of the research is put on the notice board and volunteers or interested refugees will come forward to participate. Needed documents were put on the notice board by the reception center ad researcher could not go personally because of COVID-19 situation. English speaking participants were informed about the research by the reception center authorities and volunteers were recruited for the research.

Written consent form (Appendix 2) was filled by the participants before the data collection. Informed consent ensured that participants understood the nature of the study and participated voluntarily in the study. Data was collected from sample of 9 refugees (men and women) from volunteers. There was no risk involved for the participant involved in the study such as physical, social, economic, social risk. If we analyse this thesis by the risk analysis tool, which is about finding the ratio of risk and benefits related to any action, participants were not involved with any risk. In deciding to conduct a research, researcher must carefully

weigh the risk benefit ratio of participation to individuals and also the risks to participants against potential benefits to the society (polit and Beck 2004). No risk is involved to the participants, and if we talk about benefit this study may help in decreasing the level of barriers as participants are going to suggest about overcoming barriers.

5.5 Conclusion

Refugees are considered as vulnerable group, as they are subject to have challenges when they access health care facilities in the country of refuge. Though everybody has the right to have same health care irrespective of the race, caste, sex, religion, social status and political status. In practice refugees do not enjoy this right fully in the state of refuge. In Finland they are entitled to access health care facilities, but not to the extent the residents are entitled. Existed literature documents that refugees face barriers like language difficulties, long waiting lists, inadequate cooperation at different levels, and lack of will and means to cooperate. This thesis aimed to identify various internal, structural, financial, and socio-cultural and communicational barriers faced by refugees in accessing health care services in Finland, and to propose suggestions to overcome those barriers. Findings of the thesis were similar to the existed literature and came up with barriers like internal fear, refugees' own attitude, lack of knowledge of the complicated health care system, and mistrust in the beginning, long distance between hospitals and reception centers, long waiting times for appointments, scarcity of public transport in remote areas, missing previous reports, insufficient finances, language difficulties, difficulty with interpreters and lack of cultural competency in health care system. The suggestion given by the participants to reduce the barriers were creating a parallel health care system for refugees, provision of information in English and other languages and more culturally competent health care. Findings might be useful in overcoming the barriers and for future research.

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Figures

Tables

Appendices

Appendix 1 : Questionnaire for the in- depth interview

Focused interview was comprised of following questions to find out internal, structural, financial, socio-cultural and communication barriers faced by refugees to access health care services in Finland.

Question no 1: What kind of problems or barriers you face while you access health care services in Finland?

Question no 2: What kind of internal barriers you face in accessing health care services in Finland?

Question no 3: In your opinion what measures can overcome or reduce those internal barriers?

Question no 4: What kind of structural barriers you face in accessing health care services in Finland?

Question no 5: In your opinion what the ways are to overcome or reduce those structural barriers?

Question no 8: What are various socio- cultural or communicational barriers faced by you in accessing health care services in Finland?

Question no 9: What are various steps in your opinion which can reduce or overcome those socio- cultural and communication barriers?

Question no 9: What type of financial barriers are faced by you while accessing health care services in Finland?

Question no 10: What suggestions you give in overcoming those financial barriers?

Question no 11: What is your opinion about health care for refugees in Finland?

Appendix 2 : Participant consent form

Title of the research: Barriers faced by refugees to access health care services in Finland

Location of the study: Finland

Name of the researcher: Sukhwinder Kaur

Master program student (Laurea University of Applied sciences)

Contact No and e-mail: [redacted]

sukhwinder.kaur-sodhi@laurea.fi

Supervisor: Satu Vuorela (Senior Lecturer)

Contact No and e-mail : [redacted] **satu.vuorela@laurea.fi**

I (Name of the participant) have been invited to participate in the above study. The purpose of the study is to find internal, structural, financial, communication, and socio- cultural barriers faced by refugees in accessing health care services in Finland and to give suggestions to overcome those barriers. I have read and understood the written participant information sheet. The information sheet has provided me sufficient information about above study, the purpose and execution of the study, about my rights as well as about the benefits and risks involved in it. I have had the opportunity to ask questions about the study and have had these answered satisfactorily.

I have had sufficient information of the collection, processing and transfer/disclosure of my personal data during the study and the Privacy Notice has been available. I voluntarily consent to participate in this study. I have not been pressurized or persuaded into participation. I have had enough time to consider my participation in the study. I understand that my participation is entirely voluntary and that I am free to withdraw my consent at any time, without giving any reason. I am aware that if I withdraw from the study or withdraw my consent, any data collected from me before my withdrawal can be included as part of the research data.

By signing this form, I confirm that I voluntarily consent to participate in this study.

If the legal basis of processing personal data within this study is a consent granted by the data subject, by signing I grant the consent for process my personal data. I have right to withdraw the consent regarding processing of personal data as described in the Privacy Notice.

Date

_____

Signature of Participant

Appendix 3 : Information about research and invitation to participate

Study title: Barriers faced by refugees to access health care services in Finland

We would like to invite you to take part in this research study, where barriers faced by refugees in accessing health care in Finland will be found out. We would like to invite both men and women for this study. Purpose of the study is to find internal barriers, structural barriers, financial, socio-cultural barriers, and barriers in communications faced by refugees when they access health care services in Finland. We need 10 persons who voluntarily want to participate in this research study. The research will be conducted in English, so we need participants who can speak and understand English. As health care is the basic necessity, and everybody needs the health care system to avail the health care facilities. While availing health care system as a refugee if some barriers come in the way this study may help to find out those barriers and suggestions to overcome those barriers. Data regarding barriers faced in accessing health care facilities and suggestion to overcome those barriers will be collected from volunteer participants. This information sheet describes the study and your role in it. *Before you decide, it is important that you understand why the research study is being done and what it would involve for you. Please take time to read this information and discuss it with others if You wish.* If you are interested in participating the studies, you can contact at the following numbers or email address.

Researcher: Sukhwinder Kaur
Tel. number: [redacted]
Email: sukhwinder.kaur-sodhi@student.laurea.fi

Supervisor: Satu Vuorela (Senior Lecturer)
Name of the organization – Laurea University of applied sciences
Tel. number:[redacted]
Email: satu.vuorela@laurea.fi

If there is anything that is not clear, or if you would like more information, please ask us at the above-mentioned information. After that we will ask you to sign a consent form to participate in the study. Consent form is just a consent about willing participation in the study. After filling the consent form, we need to conduct the interview related to finding internal, structural, financial, socio- cultural and communication barriers faced by you in accessing health care in Finland. Only one meeting for 30- 45 minutes will be there for the interview according to time and location of your convenience.

Voluntary nature of participation

The participation in this study is voluntary. You can withdraw from the study at any time without giving any reason and without there being any negative consequences. If You

withdraw from the study or withdraw your consent, any data collected from you before the withdrawal can be included as part of the research data.

Purpose of the study

Purpose of the study will be to identify various Internal, structural, financial, communication and socio-cultural barriers faced by refugees in accessing health care services in Finland, and to propose the solutions to overcome those barriers. There will be following three objectives of this study.1) To explore the refugee's access to health care. 2) To identify the frequent Internal, structural, financial and socio-cultural and communication barriers faced by the refugees in health care service utilization. 3) To make suggestions to overcome barriers based on findings of the study.

Organizing and funding of the research

This study is organized under Laurea University of Applied Sciences. This study is not funded by any organization. This study "Barriers faced by refugees to access health care services in Finland" will not receive any type of funds or finances from any organization or institution. Participants will not be compensated in cash or kind to provide data. Participants who will be the interested would come up to participate in the study to share their experience in barriers they are facing in accessing the health care in Finland. The findings may be helpful in future to understand the barriers and suggestions about overcoming the barriers.

Participation in the study involves

Information about barriers in accessing health care in Finland and suggestions to overcome will be collected by focused interviews. The participants will be recruited anonymously from the volunteers willing to participate in the study. The anonymous interviews of 30-45 minutes will take place. One participant is required to give interview once, so not repeated meetings will be there. Interview time will be flexible and organized with the choice and availability of the participants. Audio recording of the interview will be done, and data collected from interviews will be kept confidential. All the data will be pseudonymized so that names and places remain unidentifiable. Collected data will be kept in the file with password. The data will be saved on a personal computer of the researcher. The computer has a user code and a password, so data is protected with two passwords. The access to the data is only for the researcher. The interview data will be deleted after six months of the thesis publication. No personal data like religion, and ethnicity etc. will be collected. Interviews will focus on the problems which participants are facing in accessing health care in Finland. Data about suggestions to overcome those barriers will be collected too. Collection of data will take place between December and February.

Possible benefits of taking part

Though this study will not benefit participants financially, but findings of this study will play a role to understand the problems faced by refugees in accessing health care services in Finland. Suggestion to overcome barriers will help to make improvements in future.

Possible disadvantages and risks of taking part

There is only disadvantage or discomfort due to time used in the interview. All the risks for the participants due to potential identification aimed to control carefully.

Financial information

Participation in this study will involve no cost to You. You will receive no payment for Your participation.

Informing about the research results

Study results will be in the form of written document. In the documentation, not any identity of any kind of the participant will be revealed. Documentation will be in the form of written thesis as a part of master's degree program.

Further information

Further information related to the study can be requested from the researcher / person in charge of the study.

Contact details of the researchers

Researcher: Sukhwinder Kaur
Tel. number: [redacted]
Email: sukhwinder.kaur-sodhi@student.laurea.fi

Supervisor: Satu Vuorela (Senior Lecturer)
Name of the organization – Laurea University of applied sciences
Tel. number:[redacted]
Email: satu.vuorela@laurea.fi

Appendix to the Participant Information Sheet: A Privacy Notice for Scientific Research

Within this study, your personal data will be processed according to the European Union General Data Protection Regulation (679/2016) and current national regulation. The processing of personal data will be described in the following items.

Data controller of the study

Researcher: Sukhwinder Kaur
Tel. number: [redacted]
Email: sukhwinder.kaur-sodhi@student.laurea.fi

Responsibilities of joint controllers

There is not any joint controller to determine the purpose and means of processing personal data.

Contact person for matters related to the processing of personal data

Researcher: Sukhwinder Kaur
Tel. number: [redacted]
Email: sukhwinder.kaur-sodhi@student.laurea.fi

Types of personal data that will be collected

In personal data name of the participants will be asked which will be on the consent form. Those names will not be revealed in the study. Other data is the form of recorded voices in the interview which will be collected. Any other personal data like email address, religion, ethnicity will not be collected at any stage of the study. There is no statutory or contractual requirement to provide your personal data, participation is entirely voluntary.

Collection of personal data from other sources

Not any kind of any personal data will be collected from other sources.

Personal data protection principles

Collected data by interviews will be stored and protected by double passwords in the personal laptop of the researcher, and researcher is the only person to have the access.

For what purpose will personal data be processed?

As this study is about finding barriers to access health care for refugees in Finland. Interviews conducted will help to find out the barriers faced so, data is needed to be processed and analysed. Collection and processing the data is only for the purpose of this research study.

Nature and duration of the research (how long will the personal data be processed):

☒ One-time research ☐ Follow-up research

Duration of the research: Research study is taking place between December 2020 and May 2021.During this period data will be collected and analysed.

What happens to the personal data after the research has ended?

Within this study, personal data will be processed according to the European Union General Data Protection Regulation (679/2016) and current national regulation. All the interview responses recorded will be deleted permanently in 6 months times after publication of thesis. Electronic files and every data related to research project will be deleted completely from the laptop in 6 months after the publication of thesis is complete to have protection against unlawful processing, and against accidental loss, damage or destruction the hard copies of the participant informed consent documents including the name of the participants will be destroyed by 'shredder' in the Laurea Tikkurila Library immediately after they are scanned.

Data transfer outside of research registry:

Data will not be transferred outside the research group.

Possible transfer of personal data outside the EU or the EEA:

Your data will not be transferred outside of the EU or the EEA.

Your rights as a data subject

Because Your personal data will be used in this study, you will be registered to study registry. Your rights as a data subject are the following

- Right to obtain information on the processing of personal data
- Right of access
- Right to rectification
- Right to erasure (right to be forgotten)
- Right to withdraw the consent regarding processing of personal data
- Right to restriction of processing
- Notification obligation regarding rectification or erasure of personal data or restriction of processing
- Right to data portability
- The data subject can allow automated decision-making (including profiling) with his or her specific consent
- Right to notify the Data Protection Ombudsman if you suspect that an organization or individual is processing personal data in violation of data protection regulations.

You can exercise your rights by contacting the data controller of the study.

Personal data collected in this study will not be used for automated decision-making

In scientific research, the processing of personal data is never used in any decisions concerning the participants of the research.

Pseudonymization and anonymization

All information collected from you will be handled confidentially and according to the legislation. Individual participants will be given a code, and the data will be stored in a coded form in the research files. Results will be analysed and presented in a coded, aggregate form. Individuals cannot be identified without a code key. A code key, which can be used to identify individual research participants and their responses, will be stored researcher and the data will not be given to people outside the research group. The final research results will be reported in aggregate form, and it will be impossible to identify individual participants. Research registry will be stored in personal laptop of the researcher safe with double password for 6 months after publication of thesis.

No other personal data as defined by European Union General Data Protection Regulation (679/2016) will be collected except for names that are required on the consent form (Appendix 2). As the name of the participant may appear on the consent form; the consent form will be linked with an alpha-numeric code. The master list of names and alpha-numeric codes, consent forms will be kept securely. Hard copies of the consent form will be kept safely in the custody of the researcher in safe with a password. The list will be revealed not to anyone but the author of the study. Any soft copy or any document related to this study will be kept safely in the personal laptop of the researcher in a file with password which will be in double protection as laptop has a password too. As study is qualitative and data will be collected through interview, the data collected through interviews will be kept confidential. Interviews will be recorded in audio form and not any video recording of the interview will be done. Interview will be recorded on personal phone of the researcher and immediately after the interview data will be transferred to the personal laptop of the researcher. Data in the personal phone will be deleted permanently immediately after the transfer. Data of the interview will be kept securely in the personal laptop of the researcher in a file with the password. Personal laptop has one password too so file will be secured in double password.

Within this study, personal data will be processed according to the European Union General Data Protection Regulation (679/2016) and current national regulation. All the interview responses recorded will be deleted permanently in 6 months times after publication of thesis. Electronic files and every data related to research project will be deleted completely from the laptop in 6 months after the publication of thesis is complete to have protection against unlawful processing, and against accidental loss, damage or destruction the hard copies of the participant informed consent documents including the name of the participants will be destroyed by ‘shredder’ in the Laurea Tikkurila Library immediately after they are scanned. Data collected will not be used for any later research. Data collected will be totally destroyed as mentioned and will not be transferred or used by any other party or organization except

this research. Within this study, your personal data will be processed according to the European Union General Data Protection Regulation (679/2016).

Appendix 4 : Recruitment invitation for the interview

My name is Sukhwinder Kaur pursuing master's degree of Global Health and Crisis Management at Laurea University of Applied Sciences. We are looking for participants who would be willing to participate in research regarding barriers faced by refugees to access health care in Finland. We would like to get your perspective about your experience in accessing health care in Finland and barriers faced by you to access health care. We would like to have your opinion in overcoming those barriers.

This research is a part of master's thesis. The permission to complete this study has been received from your reception center from which data will be collected after positive response from. "The Human Sciences Ethics Committee of the Helsinki Region Universities of Applied Sciences". Interviews will be conducted to get your experience and opinions. The recruitment for the interviews will be completed by the interviewer personally, so your participation in the interview will be confidential.

During the interview, issues about barriers faced by you in accessing health care will be addressed. Your opinions, experiences, and suggestions about accessing health care in Finland will be asked in the interview. You can share your perspective regarding internal, structural, financial, socio economical and communicational barriers faced to access health care in Finland. Only one interview will take place which will be of 30- 45 minutes. There is not repeated collection of data so no more meetings or interviews will take place.

Any information provided by you will be confidential and will never be used for any other purpose. Data collected from you which is in the form of your experience and opinion will be confidential and will be analysed to answer the research question only. Within this research, personal data will be processed according to the European Union General Data Protection Regulation (679/2016) and current national regulation. All the interview responses recorded will be deleted permanently in 6 months times after publication of thesis. All the hard copies related to this research will be shredded and destroyed completely in 6 months period of publication of research.

If you are willing to participate in the research or you know anyone who can be interested in this research, please contact. It will be a great help for this study and findings might be helpful in future to overcome barriers faced by refugees to access health care in Finland.
If there are any questions regarding this research, please contact at the phone no [redacted] or at email address sukhwinder.kaur-sodhi@student.laurea.fi . You can also contact Dr. Satu Vuorela supervisor and senior lecturer at Laurea University of applied sciences at the email address satu.vuorela@laurea.fi

Appendix 5 :Poster about information of the research

WANT TO SHARE YOUR PROBLEMS ACCESSING HEALTHCARE?

THERE IS A RESEARCH GOING ON!

HELP ME IN MY MASTER'S DEGREE

- *Possibility to share your experiences*
- *All answers will be kept confidential*

CONTACT US

[redacted]

sukhwinder.kaur-sodhi@student.laurea.fi

satu.vuorela@laurea.fi

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Dr. Satu Vuorela and Dr. Teija- Kaisa Aholaakko dared to believe that this thesis can be completed with the original methodology. I appreciate the efforts Dr Teija- Kaisa made while contacting reception center and following up the whole process, without those efforts this thesis would not have been possible. I extend my appreciation to reception center management also who gave me permission to collect data. While situations became difficult, reception center took the responsibility of putting all the papers related to research on the notice board and even guided to make a poster for easy recruitment of participants. I would like to thank the manager of reception center who personally approached the population by sending them messages informing about on-going research. Finally, I would like to thank my family who provided me with great encouragement.