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## **MIGRANT CRISIS IN EUROPE:**

### **Experiences of Nurses working in reception centres of Jyväskylä area in Finland**

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Bachelor's thesis  
October 2016  
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Degree Programme in Nursing

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| Title of publication<br><b>Migrant Crisis in Europe: Experiences of nurses working in reception centres of Jyväskylä area in Finland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                          |                                     |
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| Description<br><p>The increased number of migrants that have arrived in Europe since 2000, has put new demands on health care staff and little systematic research has been done on their views and experience. The aim was to explore and describe the lived experiences of nurses working in reception centres in Jyväskylä region, in Finland and the purpose was to provide information to support and develop the competences of nurses working in this field. The methodology was qualitative design with phenomenological approach. The data were obtained through four semi-structured individual interviews and one focus group and underwent thematic analysis. The experiences of the nurses while working in the reception centres were affected by their past experiences and level of professionalism, the refugees own background, their cooperation with other services and translators and the support they received. The cultural differences between the nurses and the client affected the clients' adaptation to the health care system, their treatment and care as well as the psychology of the nurses while dealing with the challenges. The strengths of this study were that the information revealed partially filled a gap in research and can be used by all related organizations for improvement of their services. Furthermore, it gave the chance for the nurses' experiences and opinions to be expressed, and for other nurses who are interested in working in this field to enrich their competences in order to offer high quality care to their clients.</p> |                                          |                                     |
| Keywords (subjects)<br>Migrant(s), refugee(s), asylum seeker(s), Europe, Finland, Jyväskylä, nursing, nurses, reception centre(s).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                          |                                     |
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## 1 Introduction

The number of migrants has increased since 2000 in Europe. Most research on migrants' health care has been mainly around their access and use of health services, yet little systematic research has been done on experience and views of health care professionals in different countries in Europe (Priebe, Sandhu, Dias, Greacen, Ioannidis, Kluge, Krasnik, Lamkaddem, Lorant, Riera, Sarvary, Soares, Stankunas, Straßmayr, Wahibeck, Welbel, & Bogic 2011). The increasing number of migrants can put new demands on health care staff. Migrant populations may be more vulnerable having had traumatic experiences such as war, forced migration, torture and persecution (Hultsjo and Hjelm, 2005). In a study about health care professional's experiences dealing with migrants, there are several problems among which the most common problem is caring for asylum seeking refugees. Among migrants, asylum seekers are the most stressed group because beside all the traumatic experiences and adaptation to the new environment, they are nervous about their asylum seeking decision therefore the stress can cause behavior change and this change might wrongly be interpreted as cultural differences. The other problems are as followed; unexpected behavior related to cultural differences, language barrier, lack of knowledge about health care system and where to seek for help, difficulties dealing with patient's relatives, problems related to gender roles, traumatic experiences of migrants and cultural differences. In some situations staff found the attitude of immigrants threatening and degrading dealing with gender differences (Hultsjo and Hjelm, 2005). Nevertheless, in Finland there are no previous studies exploring the experiences of nurses in reception centres working with asylum seekers.

## 2 Health care services for asylum seekers

### 2.1 Refugees in Europe

Asylum is a constitutional right of each and every individual fleeing persecution in his or her country of origin or are with any reason in need of international protection. This right was first established in the 1951 Geneva Convention on the protection of refugees. (Common European Asylum System, 2015.) According to UN Refugee Agency (UNHCR) (2015, 3) it is reported that by mid-2015 around 60 million of people were displaced around the world and this number has been the highest since the Second World War. Around 20 million of these people left their countries and fled to the neighbouring countries or Europe to evade war and conflicts. As it is mentioned by Furtak(2015, 1) the highest number of refugee applicants in Europe and other neighbouring countries was from Syrian Arab Republic by mid-2015, 4.2 million, which was mainly to flee the war conflict and escape the terror of Islamic states (IS). The second highest number was from Afghanistan, with around 2.6 million.

The number of people travelling from Africa, Middle East and Asia to Europe has been rising steadily. The asylum seekers have been risking their lives to gain safety and a better life (Common European Asylum System, 2015). The total number of displaced people who have been fleeing conflict in their country and have arrived to Europe by the end of February 2016 has gone over 1.1 million (Refugee crisis, 2016).

In 2015 the number of first time asylum seekers in Europe was 66 thousand, about 5%, less than the total number of all applicants so far. A first-time asylum seekers is someone who started an asylum application for the first time in an EU member state.



This number has risen more than double since 2014. In 2015 the number of first time asylum application was 563 thousand while in 2015 this number reached 1.26 million. Among the countries with highest number of applicants are Syria, Afghanistan and Iraq (Asylum statistics, 2016).

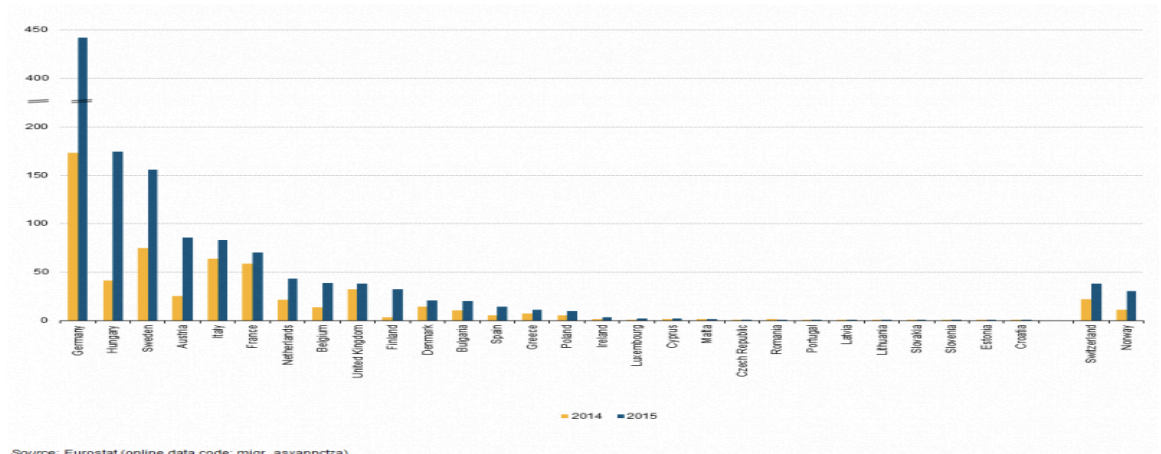


FIGURE 1 Number of (non-EU) asylum seekers in the EU and EFTA Member States, 2014 and 2015 (thousands of first time applicants)

(File: Number of (non-EU) asylum seekers in the EU and EFTA Member States, 2014 and 2015 (thousands of first time applicants) YB16.png 2016.)

Once the asylum seekers enter Europe they can freely travel to choose a country to apply for the asylum seeking process; however, according to EU's Dublin convention refugees ought to fill the application in the first nation they enter or register. But most people would prefer to go to richer countries and process their applications there (Stearns & Tirone, 2015.)

## 2.2 Refugees in Finland

The annual number of asylum seekers in Finland since 2000 was 1500-6000. In 2014 this number reached 3,651 and in 2015 this growth rapidly peaked and was predicted to reach nearly 35,000. (Rapid increase in the number of asylum seekers 2016). According to the Finnish Immigration Service (Quota Refugees

2016) the annual quota for the number of refugees for Finland was 750 since 2001. This is only the number of refugees that are designated by UNHCR, United Nations High Commissioner for Refugees, who are in need of international protection. This number increased during 2014 and 2015 to 1,050 because of the situation in Syria. In addition to this there are other asylum seekers who may come to the country border where they lodge asylum applications to the border police. From there, the asylum seekers basic information is registered and they are sent to the different municipalities and reception centres (Applying for asylum 2016.)

In Finland in 2015 there were 32,476 individuals that applied for asylum. The nations from which the largest application are received are 20,485 from Iraq, 5,215 from Afghanistan, 1,981 from Somalia and 877 from Syrian Arab Republic. Out of this number only 7,466 refugees have received the final decision and the rest are still waiting for a response in reception centres. (Statistics on asylum and refugees 2016.) The most up to date figures from beginning of January 2016 until 20th of March 2016 show that around 2,104 refugees have applied for asylum seeking process out of which the four highest numbers are 502 from Afghanistan, 406 Iraq, 172 India and 149 from Syrian Arab Republic. (Vireille tulleet turvapaikkahakemukset 2016.)

While waiting for their asylum-seeking decision the refugees can stay in the reception centres that are free of charge. According to the Finnish Immigration Service (Reception activities 2016) depending on the number of Asylum seekers the number of active reception centre can differ. There are centres specifically for minors who are without a guardian. The teenagers without a guardian under the age of 16 live inside group homes. According to law all asylum seekers are provided with some services such as accommodation, financial support and health care.

As it is mentioned in the Finnish Refugee Advice Centre there should be at least one nurse for each reception centre and the residents of the centre have to undergo full health screening when they arrive. In case of any health treatment emergency they can either access the public or the private sector without paying (Social conditions for asylum seekers 2016).

### **2.3 Nurses working in reception centres**

In European Union reception centres organization varies a lot between countries but also between areas of the same country. A reception centre can be financially and administratively dependent on the state, local authorities, NGO's or other private companies or a combination of them. In Finland the financial responsibility is shared between local authorities and state while the executive responsibility belongs to the state only. Depending on the type of organization the quality of reception centre differs, as well as the personnel at the centre. There are reception centres that are fully equipped with doctors, nurses, social workers, psychologists and non-professional care givers and others that may be limited to social workers and a nurse. The criteria are based on the needs of asylum seekers in each centre and the countries regulations, for example there are centres for minors, for women and children, or for disabled and elderly people. (European migration Network 2014, 13-18; Perrin 1996, 160.)

Finland provides health care services through the reception centres organized by the state, municipalities and Finnish Red Cross. Each reception centre has a specialized public health nurse or a registered nurse. The roles of the nurses vary based on the needs of the asylum seekers that are evaluated together with the social worker through interviews and health checks. Within the first 15 days upon arrival at the centre the nurse will inform the asylum seeker about the health and social services provided by the centre, the municipality or the private sector. (Refugees and asylum-seekers 2016.)

The American Public Health Association (The definition and practice of public health nursing 2013) defines public health nursing as “the practice of promoting and protecting the health of populations using the knowledge from nursing, social and public health sciences”. The nurse can use the five key elements of public health nursing practice and adapt them to the asylum seekers of the reception centre and the communities that they belong to. At first focus should be given to the health needs of the group of the asylum seekers of the specific reception centre and the sub-groups that exist inside of it. An example of a sub-group can be children or pregnant women. The nurse will assess the health of each group and the individuals in a systematic and comprehensive way and evaluate the factors that affect their health. After evaluation, the prevention measures and the interventions needed should affect all the determinants of their health, including the asylum seekers themselves, their families, the community and the health and social services providers. (The definition and practice of public health nursing 2013.)

#### **2.4 Experiences of health care professionals working with migrants**

Priebe, et al., (2011) categorize the problems that health care individuals in Europe face in relation to migrants into eight types. These problems are cultural differences, lack of familiarity with health care system, social deprivation and traumatic experience, language barrier, difficulties in arranging necessary care for migrants with no health care coverage, different understanding of illness and treatment, lack of access to medical history and negative attitude between healthcare workers and patients. The most commonly reported problem is language barrier. The common problems according to language barrier are restricted access to interpreting services, confidentiality problems using an interpreter especially when the interpreter is from the same community, risk of wrong diagnosis and misunderstanding and selective translation when the translation is done by family members.

In a study done in Denmark on health care professional experiences with migrants the findings are quite similar. The professionals mentioned lack of medical records, language barrier, formal barriers to gain necessary treatment and further referrals and police involvement and other authorities. (Jensen, Norredam, Draebel, Bogic, Priebe, Krasnik 2011.)

In another study that was carried out among mental health service providers on their experience with Chinese immigrants similar problems have been found. These include concerns in confidentiality issues, communication difficulty, service constraint, mental health literacy, stigma and discrimination. (Blignault, Ponzio, Rong & Eisenbruch 2008.)

According to Teng, Robertson Blackmore and Stewart (2007) four types of barriers were recognized among health care providers for immigrant women. The first type is the practical barriers that include language barrier and knowing how to access the services and the second type is cultural barrier which includes stigma. The two other groups are professional and social challenges, including cultural uncertainty experience, being afraid of incompetency and inadequate assessment tools. Therefore the results show that working with migrants is more challenging not only because of the barriers but also the difficulties in delivering the suitable treatment.

The experiences of the health care staff regarding immigrant patients, has also been studied in Hospitals. Results revealed that most of the staff lacks appropriate knowledge on immigrants and they mostly learn about different cultures through media and patients contacts instead of courses or trainings. Among the staff, nurses and doctors had the most positive attitude towards immigrants compared to assistant nurses and many health care workers were unhappy about the way immigrants use health services. These include communication problems, overreaction to pain, unsuitable expectations regarding

medication and troubles in understanding counselling. (Michaelsen, Krasnik, Nielsen, Norredam & Torres 2004.)

Finally, in another study (Hjelm, Isacson & Apelqvist 1998) about 140 health care professionals were asked open ended questions about differences between immigrant diabetic patients and other diabetic patients. The result showed that migrants were thought as less knowledgeable about body and diabetes. In addition it was believed that migrants value social relation and older habits comparing to non-migrant population. Also immigrants focus more on home remedies when ill and visit more specialist doctors. 89% of the health care professional mentioned communication difficulties and differences in culture as issues that affect the treatment process. In Finland, there is limited previous research exploring the experiences of nurses in reception centres working with asylum seekers.

### **3 Aim, purpose and research question**

The aim of this study was to explore and describe the lived experiences of nurses working in reception centres in Jyväskylä region, in Finland. The purpose of this study was to provide information to support and develop the competences of the nurses working for asylum seekers in reception centres. The main research question was: What are the experiences of nurses in reception centres working with asylum seekers in Jyväskylä region.

## **4 Methods**

### **4.1 Study design**

The design of this study was qualitative. Our study's own aim makes qualitative design the most appropriate for exploring the experiences of the nurses in the refugee centres, using a phenomenological approach. Phenomenological

approach is aiming to understand and describe the phenomenon, the experiences of its participants and their meaning (Al-Busaidi 2008).

Maxwell (2008, 220-222) states that there are three kinds of goals that a researcher shall have to implement a study, personal goals, practical goals and intellectual goals. Indications for qualitative study include the intellectual goals of wanting to understand the events, actions, and situations that the participants have experienced how they explain those experiences and what is the influence on them. As well as understanding and exploring the context in which those experiences occurred and the way they are shaped. The purpose of our study comes in line with the practical goals of Maxwell's design, where qualitative research can be used when studies intend to help improve existing practice and the results aim to be understandable and reliable to the participants and others.

## **4.2 Participants and sampling**

The sampling was purposeful; we selected the participants based on the information they could provide to support our aim. As Patton (2002, 230) states "The logic and power of purposeful sampling lie in selecting information-rich cases for study in depth." In our study the participants were 6 registered nurses working in reception centres in Jyväskylä area. The recruitment started with a list of the reception centres for asylum seekers in Finland, we choose those who belong to Jyväskylä area and contacted their supervisors. The research plan and confidentiality agreement (Appendix 1) were sent to their supervisors, who gave us the research permission for each centre. After permission was gained, the contact information of the nurses was available to us. The nurses were asked by telephone whether they were interested in participating in our study and eventually we arranged 5 interview meetings.

### **4.3 Data collection**

Our data collection method was semi structured individual interviews and one focus group. Semi structured interviews give the interviewer the freedom to ask for further questions and clarifications. (Patton 2002, 347.) In our interviews the structured questions helped to bring up the main topics of our previous research review. The open-ended style questions and probing assisted in further exploring the topics according to the participant's responses. The interview guide is displayed on appendix 2. During the semi-structure interviews the instant data that was obtained provided us with the flexibility to ask for explanations and maintained a more relaxed atmosphere for the participants. The interviews took place in the reception centres after arranging a meeting with the nurses. In two of the interviews there were two interviewers present, the one started and guided the interview and the other kept notes and audiotaped. The other 3 interviews were conducted with one interviewer who was asking questions, keeping notes and audiotaping. The interviews were audiotaped and the notes were taken with the consent of the nurse. The audiotaping assisted in not losing information given by the interviewees. (Patton 2002, p. 380-382.) The written notes assisted the interviewers to form further questions while interviewing and recorded the nonverbal communication as well (Patton 2002, 383.) Before the interviews, an oral consent was obtained from the nurses and they were reminded that their participation is voluntary. There were no limitations on the length of the interviews, since the nature of the nurses' job required breaks or rescheduling.

### **4.4 Analysis of data**

The data acquired went through thematic analysis during and after the interview. The analysis during the interview was vital to create further questions to obtain details and further exploring of the topic. (Maxwell 2008, 236). The procedure started with transcription of the audio material into written text,



followed by thorough reading and it was reduced through highlighting with different colour markers. Similar themes were highlighted with the same colour and later were clustered into themes. The information was combined with the written notes. While writing the findings further analysis of the themes was done before combining the existing literature into the discussion. (Braun & Clarke 2006, 15-23)

#### **4.5 Ethical considerations**

Undertaking this study required research permission by the refugee centres' supervisors in order to examine any ethical issues that could possibly arise, gain access to the centres and get permission to obtain information from nurses. Nurses themselves were provided with a consent form or were orally reassured prior to the interview that their identity, identities of the asylum seekers and any information related to the location, name and condition of the centre would stay confidential. The nurses were also informed that they could withdraw their participation at any time since it was completely voluntary. (Finnish Advisory Board on Research Integrity 2012)

### **5 Findings**

The findings were organized into 11 themes based on factors that amalgamated in shaping the experiences of the nurses in reception centres.

#### **5.1 Intimacy between the nurses and the clients.**

Interviewees mentioned a few cases where the clients refused to take their clothes off for examination or refused to be touched by the female nurse unless she was wearing gloves. The nurses noted some differences between people from different cultures. Arabs, mainly Iraqis seemed more protective of their bodies and demanded a different way of treatment while Somalians and Afghanis were more cooperative. There were no issues though, when nurse

and client were of the same gender. In most cases the problem was resolved after discussion and explanation about the position of the women and the nurse in Finnish society. It was also mentioned that intimacy was mainly a trust issue between the nurse and the clients, that was improved with time and after they got to know each other.

*“I have couple of guys in here who are very religious and women cannot touch them. Luckily we have a male nurse then I call him and ask him to come. For some it is enough that I wear two gloves. Normally I try first managing by explaining the nurses’ role in Finnish society.”*

## **5.2 Familiarity of the refugees with the Finnish health care system and nurses’ role.**

All nurses explained their position, responsibilities, and capabilities to the clients from the first meeting. Most nurses said that that first discussion was enough to establish their role in the centre and gain the trust of the clients. However, there were cases where nurses had to explain many times what they could or could not do and some faced negative behaviours because the clients did not trust them yet. The main challenges they faced were that clients wanted to see the doctor directly without being examined by nurses first or calling the ambulance unnecessarily, coming to the office without appointment and coming late. The nurses pointed out the importance of keeping the appointment system while in the centre; because it familiarizes them with the way they can access Finnish health care after they exit the reception centre. However, nurses found it difficult to refuse services out of appointment hours and offered their care nevertheless, mainly out of compassion and understanding of their condition.

*“Even if I have explained that many times, for example guys from Iraq it is very different kind of health care they have in their country, I need to explain again because*

*the Finnish health care system is very bureaucratic. In here always you have to talk to the nurse first if want to go to doctor. Then you go to general doctor and then to specialist and the specialist might then refer you to another specialist."*

The nurses faced challenges in different levels including the perception of treatment that clients had. Interviewees mentioned that clients wanted medication in form of injection even though there were alternative methods or there was no injection for the specific health issue. Some of them also wanted specific medication that others were prescribed even though it was not suitable for their case. There were also others who were coming to talk about kidney pain because other people from the centre had it.

*"I want that medicine also."*

Some had trouble understanding that some medication should be bought from the pharmacy individually rather than given by the nurse.

*"When first coming here they thought I had to give medicine for everything, when said no or that you have to go to the pharmacy to buy them yourself, they said: "No, no we don't want just give some medicine"."*

In other cases, for example when they had flu or viral respiratory problems, clients demanded antibiotics and nurses had to explain many times that it is not possible to get them for a simple flu. The responders also highlighted the demand for specific psychiatric medication. The nurses felt mostly frustrated because the clients requested for stronger medications that could not be prescribed for various reasons. Nurses also faced a challenge with the clients who demanded to be treated medically for sleeping problems or asking for stronger medications.

*"Some guys have strong opinions about medication and for example ask for strong medication for sleeping problems. But in Finland you cannot get strong medication*

*without prescription. Of course you can have Melatonin even for that first we have to figure out if it is rhythm problem or sleeping problem. They are some guys who need to talk to their family during the night because of the time differences but that is not sleeping problem that is rhythm problem. But if there is sleeping problem we start first with Melatonin and if that does not help then they can go to doctor."*

### **5.3 Treating chronic diseases**

Chronic diseases in reception centres were fully treated only when they were emergency or serious. Clients with diseases like asthma, diabetes and acute dental problems received full treatment but others, who suffered from mental health and musculoskeletal disorder, were minimally supported. The responders stated that very often patients were complaining for chronic pains, like pains in the back, kidney pain, limb pains, headaches and chest pains. At the beginning the main challenge for both nurses and clients was to localize the pain and describe it. In cases where the pain had an obvious cause or there was a diagnosis for it, like kidney pain the treatment was given when possible, according to the guidelines. When the pain was in the chest, nurses made sure, together with the doctor, that the patients did not suffer from any cardiovascular disease and that the reason for the pain could have some other explanations. There were however many clients that could not localize or explain the pain they had. Nurses attributed this problem to language barrier.

*"They think of pain differently, it is not so easy to understand if someone says "I have pain in the chest", is it a bad feeling or is it mental issue? Is it a heart attack or is it something else? "*

Mental health diseases were very common in all the centres. The most common ones were post-traumatic stress disorder (PTSD) and depression that were sometimes accompanied by suicidal behaviour.

In some cases, usually when mental health issues and pain were involved, nurses were giving vitamins tablets instead of medication because discussion and consultation was not considered treatment by the clients.

*“Usually they come because they want attention. Sometimes they need just someone to discuss and because they have nothing else to do they come here and they talk about the kidneys but the problem is something else, usually mental. Sometimes they want something concrete, they come here talk about kidney pain and they take a vitamin and the vitamin helps. Then, after two or three weeks they come here again”.*

Nurses felt mostly frustrated because they felt the need to help them with their mental health issue, but they could not.

*“I cannot do psychotherapy and we can only give them a few psychiatric consultations. So, when they come here I can just discuss with them.”*

*“I feel sorry that I cannot take care of them, I have this bad feeling. But these are the orders; you can do this and not this”*

*“There is no other help, we just give the medicines and they go home or they come back and we listen for a while and listen again and again. We understand the patient’s problem but we do not have a solution, and it is really frustrating.”*

Nurse mentioned that the mental problems get worse since the stress for the asylum decision piles up and some had already received a negative one.

*“Before their decision they still have hope after their decision they don’t have hope anymore some of them take it very seriously and they are maybe suicidal after the decision “*

*“They do not know if they can stay on Finland or not. It is a really big stress and there are suicidal behaviours, depression, alcohol and drug addictions.”*

Sleeping problems, stress, hopelessness and sorrow affect the clients' mental health as well as other residents of the centres and even the workers'.

*"The negative decision affects their mental health and also changes the atmosphere of the whole centre. Then you should try hard to cheer up and give support."*

Dental hygiene was an issue in some centres where nurses mentioned that problems exist in all age groups. The common issues were very bad mouth smell, gum bleeding and black and broken teeth in most of the patients.

*"The problem is they do not care about their teeth."*

Nurses said that the waiting list for the dentist is huge and the parents or school do not educate and teach the children dental hygiene.

#### **5.4 Maintaining professionalism**

There were many factors that helped nurses maintain their professionalism throughout their work. They had to provide education for other workers in the reception centre, respect the individuality of the patients always, manage their work stress effectively, feel that their work was appreciated and wear work uniform.

As the participants mentioned there are other workers in reception centres with different educational backgrounds and some with no university degree. The nurses worked in the centre on weekdays from 8 am to 4 p.m. Therefore, when the nurse was not available some wrong decisions could be made. One interviewee mentioned that she has her phone on at home when she is not present in the centre and has told the colleagues to call if an emergency happens.

*"We have ohjajat (counsellors) who have very different education some have been working in jail and some in day care centre. In the evening if there are acute cases of course they can call the hospital to ask for information or take them to emergency but I*

*have also educated them on which cases need to be taken to hospital and which can wait till I come in the morning. At the beginning of this year there were some problems with those with urine stones. They had not drunk enough liquid and were taken to hospital because of pain and what the hospital did? Gave them liquid and pain killers."*

How to manage work stress was another important point. Most of the participants mentioned that they try to talk to their colleagues about the problems and challenges. Especially those colleagues from the same nationality as the asylum seekers, because they can explain issues aroused from cultural differences. Trying to find out the reason behind a behaviour that has caused stress can help the nurses deal with it easier.

*"I try to figure out what is behind that kind of behaviour that caused stress but sometimes Arabic guys can be loud if you say no to them and because we are not used to it, it can be sometimes scary. But now I know them and this does not scare me and I know how to deal with it. Now I try what is behind that kind of behaviour they can be scared, they can have pain, many kind of thing behind that kind of behaving. With cultural problems, I have my colleagues from same religion and nationality so I talk with him/her and search for the answers."*

Participants believe that because of the nature of the job every individual might need different methods of treatment and this demands respecting clients' individuality.

*"Sometimes you have to accept that people have different opinions. For these kinds of situation Red Cross guideline is respecting individuality and respecting people's background"*

*"People are different from different cultures and background and each one will have his issue. I try to find solution for every case differently based on their needs and condition"*

Some of the interviewees were hesitant to apply for this job in the beginning because they had not worked with children or refugees before. After starting

working and regardless of the challenges they faced, they all reported that they like their jobs and it is very rewarding.

*“I think now that I look back it was nice that I created this all by myself and started a new thing”*

*“I like this job. Even if it is sometimes very hard there are good experiences in here. I have acute patients in here that when they came to Finland they knew their diagnosis but they did not have any medication now they are fine. And we have done so much with them. I am very satisfied.”*

*“I learned a lot of things about myself through this.”*

They also reported that they felt very appreciated by the refugees, which made them very happy and satisfied.

*“There are patients who say to us that “you are angels and I will never forget you.””*

A participant from a Red Cross reception centre noted that wearing the Red Cross uniforms can bring bad memories from asylum seekers with traumatic experiences. Therefore, the nurse and other workers tried not to wear the uniform all the time.

*“They don’t like us wearing official clothes of Red Cross, because it reminds them of their bad experiences in other Red Cross centres in other countries.”*

## **5.5 Cooperation between nurses of the reception centres and other health, public or private services**

Nurses in the reception centre had to cooperate with people working in the centre as well as people who worked in very different services. Cooperation between nurses themselves and the counsellors was very good and supportive. The nurses were helping and supporting each other on cases and psychologically. The counsellors were very helpful in suggesting and pinpointing to the nurses, issues that might need their care but the clients were afraid or ashamed to talk about. They were also following their suggestions and guide-



lines that nurses had given them, as well as warnings for possible symptoms and behaviours.

Working with public health care centres and central hospital was a struggle for some nurses at the beginning. Nurses' job was to refer clients for dental, medical and lab examinations. The main issues were the lack of information and misconceptions about the number of clients that were sent there, the existence of communicable diseases and the amount of paperwork that was supposed to be sent back and forth.

*"They were afraid that they could not handle all these people and they were really angry, they said "you should not come here and take care of them by yourselves. ""*

*"Some of the nurses in health care centres and hospital do not know that there is a nurse working in the reception centre and that the asylum seekers get health care support in the centres. "*

Their cooperation with the Finnish immigration office was good, despite the big amount of paper work requested. There were however suggestions for extra and more precise information. The main issue with the private health care centres, which was mentioned by all nurses, was that the medical data of the patients after their visits was not sent on time or at all. All interviewees highlighted the amount of paperwork that they had to process after their collaboration with any of the services. This took crucial time from their work that could be spent caring for the clients.

## **5.6 Dealing with stigma**

Some participants believed that mental health disorders are not easily accepted because of the stigma and the fear of being bullied. However, it was also noted by some of the respondents that acceptance of the mental health issues

depends on how you explain the matter and the way you talk about mental health.

*“It is very challenging to them to accept what mental problem they have. However, it can be that in different cultures they can take care of these problems differently. Sometimes they do not talk about their problems easily and are afraid. We have lots of cases of posttraumatic disorders but they are afraid to talk about it because they may be called by others crazy. I try to explain them what it means, what you need to do in future and all this and I give them time to accept it, because I cannot force anybody into treatment”*

*“Talking about mental issues is not anyway easy because they are difficult issues by themselves, understanding and accepting it is not the problem. However, in many places they say that in some cultures it can be more difficult but I have not seen it. It is also how you talk about mental issue. Even if you tell a Finnish man you have this mental issues he won't accept it, but you should first start with how are you and have you been down lately do you have something that troubles your mind? Then build up the experience that what is wrong with you and what you are experiencing. How we as nurses see the whole concept of mental health or psychiatric nursing and how we as individuals think about human being. So in my opinion giving a diagnosis is not useful just it is about people's experiences and how they feel about the things they have gone through”*

Providing sexual health care to the clients of the centres was challenge at the beginning but it got better as trust was built between the nurses and the clients. Interviewees mentioned that there is stigma in the community about sexual issues based on cultural beliefs but there were many female clients who approached the nurses for contraception methods and gynaecological check-ups. Central hospital workers were unaware of the diseases that clients could have so there was stigma toward the asylum seekers.

*“Central hospital thought that they have “exotic diseases” but it is just flu, headache, back pain, leg pain, and pain everywhere.”*

### 5.7 Nurses' past job experiences

Most of the interviewees had acute/intensive care and mental health care experience. The nurses with connections with people who worked in health centres, hospitals and Red Cross said that it made their job easier and faster. A participant who had a long experience of working in acute and emergency wards in different countries had a very positive attitude towards cultural differences and had tried to learn languages to communicate with the patients in their mother tongue.

*"I have read Quoran to know about their religion and I have a notebook with the vocabularies in Farsi and Arabic to communicate with them in their language it helps a lot for them to understand."*

Another important finding that was mentioned by one of the interviewees was that not many people want to work as a nurse in a reception centre. They are scared which results from a misunderstanding about the nature of the job and a fear of the unknown.

*"There should be two nurses in every centre but up to now we have problem because we have not found any other nurses in here because this is scary, there is a misunderstanding, this is so new thing"*

Another interviewee working in a reception centre mentioned that some of the nurses in health care centres and hospital do not have enough information on nursing care in the asylum seeking process.

*"Nurses who are not working in reception centre for example in central hospital have wrong or different beliefs that asylum seekers do not get health care support in the centres"*

### 5.8 Job related training from Immigration office and Red Cross.

Most of the participants said that they did not get any training specifically for this job at the beginning and they learned through their experiences; however, later there were some trainings and guidelines by the related organizations.

*“No one got any information the situation last year was chaos and we went through. All nurses who started to work last year but we just had to build our jobs. There were some basic plans.”*

*“We read the instructions from Internet and how things should go. When I first started my job the first day, people were knocking on the door with different problems and I did not know what to do”*

On the other hand, it was also noted by some participants that they got enough training, guidelines and support by Red Cross and immigration office.

*“There are some information packages by immigration office and Red Cross in the beginning but there is so much that you have to learn by yourself only through experience”*

## **5.9 Background of the asylum seekers**

Asylum seekers background played an important role on how nurses provided their care. The knowledge and information they had when they came to the reception centre, traumatic experiences, the origin of the asylum seeker, the length of their stay and culture seemed to be the main factors. The respondents mentioned that most of the asylum seekers do not have basic health literacy; they do not know basic body anatomy, common diseases or treatment for minor injuries. The level of health literacy was however different between asylum seekers from different countries.

*“Lack of education in some patients makes understanding the basics of health more difficult. Some of them do not have any knowledge about how their body works and where their heart is and what it does. There are some that for example know they have urine stones but they do not why they have urine stones, what area the kidneys are and what they do and how the disease is treated.”*

*“If there is something small like a wound on the finger, they come here because they can't treat it themselves.”*

*“They were saying they have kidney pain but they were showing their belly.”*

Respondents also believed that traumatic experiences can affect your learning therefore those with these experiences cannot remember the information the nurse gives them. Thus, you need to explain it more and repeat it.

*“Of course it depends how you explain things, if it is easy to understand it helps. But in traumatic conditions they just don’t remember and the experience goes in a cycle around and round and you need to explain once again and more and more and more, it is not because of the people and level of intelligence it is related to their experience.”*

An interviewee also said that knowledge is not a big problem and normally they learn after they explain the topic clearly.

Some participants said that the origin of the client could affect their reactions. This was mentioned referring to the perception of pain, being loud and religiousness. Most of the attendants agreed that people from Iraq have stronger reactions to pain and show pain in different ways and they are sometimes louder than other nationalities. However, it was mentioned by two participants that low pain tolerance could be a result of traumatic experiences. Also, some people from certain regions are more religious, such as Iraq, and it can sometimes affect the process of care.

*“Those from Iraq are more religious I cannot touch them; they also show severe reactions to pain sometimes like epileptic symptoms in case of fever and pain”*

*“Sometime those from Arab nationalities react strongly to pain and they are louder, but this might be low toleration to pain because of the traumatic experiences”*

There were contrasting opinions about the relation of knowledge and origin of the asylum seekers. A participant believed that most of the asylum seekers from Iraq are educated and knowledgeable and those from Afghanistan lack necessary knowledge about their own body. On the contrary, some interviewees believed that some clients from Iraq /Arab speakers have less knowledge, education and information on their health and body.

*“They have different kinds of education. Some of them know basic health care and how to treat themselves. Usually guys from Iraq have high education or some kind but*

*most of those guys from Afghanistan they have low education and do not have any idea how to treat themselves”*

Then length of stay and cultural differences can affect the understanding of differences and the learning.

*“It depends where they are from, with some nationalities, it is more challenging because of the cultural differences, also some are here for longer and we already know each other and how things work and some are also now used to the differences in culture and have accepted it”*

### **5.10 Use of interpreters**

The interviewees used the services of the translators based on the severity of the case and the degree of the communication with the patient. The interpreters were either invited to the centre or contacted by phone. Both options needed time and scheduling.

*“Taking an interpreter takes time and because of the number of asylum seekers, sometimes they are not always available therefore in non-official situations we try to manage with the amount of language they know or other kinds of help”*

Not all translators understand and speak all the dialects of the Farsi and Arabic for example. Therefore, most of the participants try to use the same translator and company that they know suits their cases better and have had the experience working with.

*“If you are speaking Arabic you are from morocco but you are translating for an Iraqi guy there might be different words for different things. I like to use the same translator because I know them and I know they work well. “*

*“Some translators aren’t professional or don’t have good lingual skills which might make the situation worse. They have translated to things that I have not said and it took to situation to wrong directions.”*

*“Once there was a problem with a phone Arabic translation. I could not get from those I know and I called to another company the patient was talking for long but then he just said that the patient has some anxieties”*

*“Some Arabic people ask that the translator speaks their specific dialect.”*

A participant had used colleagues who have the same language as the patients to help with the translation with the patient’s consent.

*“ We have one of the ohjajat (counsellors) who is Arabic if there are some fast thing and not official we can use him/her also we have a colleague who speaks kurdi and Persia, sometimes it is very helpful but we always ask the patients if it is ok and those ohjajat have to stay silent”*

Having interpreters in discussing health issues could give patients the feeling they are more understood. It also had helped the nurse in understanding the issues if the interpreter and the client were from the same culture.

*“We quite often manage without the translators but we have to get them so that the patients feel better. Even if I understand the patient’s problem it is a feeling of to be heard. People like to be listened to.”*

*“If we know the case and the translator has been here before several times and he is familiar with the topic we can sometimes discuss some difficult issues with the translators and this can help.”*

*“Translating and understanding what kind of mental health patients have is a challenge for example Somalian people tell their heart is black when they want to talk about big sorrow and luckily a good translator from the same culture can describe this.”*

### **5.11 Primary health check-up and interview**

Primary health check-up and interview is the only way the nurse can know about the patient’s medical history before entering Finland. Also, during this interview the nurse introduces the centre and the rules from the nursing point of view. The nurse gives the necessary information about hygiene and health

at the same time. It is believed after this interview and discussion, they had fewer problems. Although the participants asked about the medical history of the patient when they entered the reception centre, it may be that they later realise that the clients have had diseases that they did not mention at interview.

*“When they came in here even if they have been in other centres I explain everything, like when they can get the appointments how it is arrange, the vaccinations, examination and common health issues and every kind of that things. We are doing the health interview with the official translator and we fill a form with everyone of course sometimes even I have given health interview they can come to me in a couple of months and talk to me about their health issues and then I see they have many more health issues that they have not said I don’t know why maybe there are some believes that immigration office wants to know what disease they have and this might affect their decision there is these kinds of rumours”*

*“For example the usage of antibiotics was solved after the first interview with some asylum seekers and they understood it, we cannot access the health history unfortunately before they enter Finland. We need to trust them”*

## **6 Discussion**

The aim of this study was to describe nurses’ experiences working in reception centres in Jyväskylä area. The purpose of this study was to explore and provide information to be used as a developmental and support tool for nurses’ competences working with asylum seekers in the reception centres.

### **6.1 Intimacy between the nurses and the clients.**

The findings showed that intimacy and modesty were a challenge for the nurses at the beginning, which was affected by the cultural background of the clients, the trust between them and the appropriate counselling. These results



are in line with existing research. As Rassool (2015) stated, nurses should be aware of the client's need of modesty and privacy and the appropriate use of touch during the care process.

## **6.2 Familiarity of the refugees with the Finnish health care system and nurse's role**

Similarly, Pribe et al. and Teng et al., note that nurses faced challenges until the clients eventually adapted to the new health care system. Persistence, patience and repetition were the competences used in order to face the problem. The results also showed that the perception of treatment, medication and illness was different between the clients and the health workers, which was also stated by Pribe et al (2011). The nurses managed to resolve the issue by clarifying and repeating to the patients the guidelines that must be followed based on each case.

## **6.3 Treating chronic diseases**

The finding showed that clients with chronic diseases like chronic pain, dental problems and mental health disorders are the ones who challenged the nurses most. The Australian Medical Association (2015) mentioned that refugees and asylum seekers may suffer from poor dental hygiene and mental health disorders. This is in line with the respondents' information about the bad condition of their client's oral health and psychological status. The nurses expressed their frustration about the fact that clients did not always understand the importance of mouth hygiene. Mental health and chronic pain issues were also a challenge for them since they could not offer sufficient support and care to the clients due to health coverage limitations. As Priebe et al (2011) and Jensen et al. (2011) mentioned, there were barriers that limit migrants' ability to access necessary treatment. It was also shown that negative asylum seeking decisions had negative effect on the asylum seekers' health and the reception centres'

atmosphere. This could cause stress, sleeping problems, hopelessness and suicidal tendencies and sorrow. It could also affect the mental health problems the asylum seekers already have. Therefore, after this decision nurses needed to be more supportive and attentive. Yle (2016) also reported that the suicide attempts by the asylum seekers in reception centres of Helsinki had risen and resulted in deaths, after receiving negative asylum decisions.

#### **6.4 Maintaining professionalism**

Further findings revealed key points relating to nurses as health professionals and professionalism. It was found that besides all the responsibilities a nurse had in the reception centre, to maintain professionalism they had the responsibility of educating other workers and giving them enough information on how to follow care when nurses were not available in the centres. All these responsibilities and the nature of the job created a great deal of stress for the nurses. Therefore, they need professional support and support from their colleagues. It was found that talking to co-workers especially those with the same culture and nationality of the asylum seekers could release the stress and also could help the nurse find better solutions for the stressful situations arising from cultural differences. Considering the asylum seeker's traumatic background, respecting individuality and believing in human being's differences could also help them in being more tolerant. However, none of the participants mentioned clinical supervision as a means of support. According to Teasdale, Brocklehurst and Thom (2001) it is important to maintain both informal and formal support for the nurses. One of the reasons for clinical support is to give individual support to help the nurses manage work pressure. Also, clinical supervision has increased the nurses' sense of professionalism and improved their self-image. It was reported that wearing formal Red Cross uniforms could cause some stress for the asylum seekers by reminding them of challenging experiences. Not wearing the formal uniform could create more

comfort in the reception centre. A high sense of job appreciation was recorded among the nurses who work in reception centres. They feel that their job is rewarding and their efforts are appreciated by asylum seekers. The fact that they had learned through the working experience had given them a sense of pride and responsibility.

### **6.5 Cooperation between nurses of the reception centres and other health public and private services.**

Respondents mention that their cooperation with other workers and nurses was very good and supportive. There were challenges when working with public health centers and the central hospital due to misconceptions and lack of information. Paperwork when collaborating with Immigration office and private health centers was their main issue.

### **6.6 Dealing with stigma**

Another result of this study was that of stigma being a barrier to nurses in the implementation of mental and sexual health care of asylum seekers. Likewise, Teng et al. also reported stigma a cultural barrier that hinders care. Acceptance of the mental health issues was very challenging because of the stigma and the fear of being called crazy by other members who live in the reception centre. However, there was an opinion by a nurse working formerly as a mental health nurse that acceptance of mental health disorders can depend on the way of describing it. Based on this she had never had a problem with stigma about mental health issues. The results of Strijk, Meijel and Gamel (2010) are in line with our findings that the asylum seekers in a reception centre were afraid and ashamed of being stigmatized when it came to mental health problems. They were worried about being called crazy by other members of the community.

## 6.7 Nurses' past job experiences

The findings revealed that the background and experiences of the nurses working in reception centres have significant positive effect on their jobs. Those nurses with acute care and mental health experience as well as those having worked in different countries believed that it has had a great impact on their understanding and helped in giving the different sorts of care needed in a reception centre. It was also reported that lack of knowledge on the nature of the job can negatively affect the willingness to work in reception centres as professional nurses. Similarly Repo, Vahlberg, Salminen, Papadopoulos and Leino-kilppi (2016) mentioned that to provide culturally responsive and effective health care services and improve health outcomes and patients' satisfaction, nurses should be culturally competent. The length of working experience, nurses' ethnocentrism, higher level of education, additional education on multicultural nursing, linguistic and communication skills affect cultural competency. It was found that some of the nurses who lack enough knowledge on the kind of nursing care needed in a reception centre or multinational experiences are scared and consequently refuse to work in reception centres. As mentioned before by the American Public Health Association (2013) the nurse should use the five key elements of public health nursing practice that was mentioned earlier and adapt them to the asylum seekers of the reception centre and the communities that they belong to and assessing the health of each group and individuals systematically and evaluate the factors that affect their health. After that the nurse should take the prevention measures and the interventions needed should affect all the determinants of their health. (The definition and practice of public health nursing 2013) It was also revealed that some of the health care professionals working in hospitals and health care centres do not have enough knowledge on the nursing care in asylum seeking process and they think in reception centres there is no nurse to give information and support to asylum seekers. Similar to our findings, a

study that was done to measure the differences in experience and knowledge among hospital staffs in regards to immigrant patients, it was found that the majority of professional groups gain their experience from patient contact and media rather than courses or other colleagues (Michaelsen, Krasnik, Nielsen, Norredan and Torres, 2004).

The results revealed that none of the nurses received specific trainings before starting their jobs. However, later there was some guidelines and information on line from related organizations for nurses to refer to. A few nurses felt no need for the training; however, the rest of the nurses did not know what sorts of care they should provide at the beginning of their job.

## **6.8 Background of the asylum seekers**

It can be argued that asylum seekers lack enough knowledge on the basics of health (mental and physical) and their body. Participants believed that this would not hinder care, however it increased the need to continuously explain and offer more counselling. It was reported that this can be because of the traumatic experiences asylum seekers have had and these experiences can gradual the learning process. It was revealed that patient's origin could affect their reaction to pain. However, some nurses explained this as a consequence of traumatic experiences. As a result, they have lower tolerance to pain. Also, it was revealed that religion, cultural differences and the length of stay could affect the process of care. In the study done by Michaelson et al. (2004) there were similar findings. According to the study many health care workers in a hospital were unhappy about the immigrant's over-reaction to pain and troubles in understanding counselling. In a similar study by Hjelm et al. (1998) it was shown that migrants were thought less knowledgeable about body and also health care professionals mentioned differences in the culture as an issue that affects the treatment process.

## **6.9 Use of interpreters**

Another issue mentioned by the nurses was the need to use interpreters and its related challenges. It was noted that hiring a translator was a time-consuming process therefore in emergency non-official situations, having the patients' permission, they use other ways to communicate such as asking asylum seeker's friends or colleagues who know English or the local language to translate or using the asylum seekers limited knowledge on Finnish language to communicate. It was found that some interpreters did not have the language proficiency in knowing different dialects of a language and they were not able to understand all dialects flawlessly. There were also some interpreters who lack professionalism and lingual skills and this has caused misunderstandings and some interpreters translate selectively. As a result, nurses prefer to hire the same interpreters whom they are sure have good skills in translation. Hiring an interpreter was also noted to have a positive effect on the way the patient feels when she or he is talking to the nurse in the reception centres. A translator/interpreter with the same culture as the patient and good skills was believed to help the nurses in faster understanding of the issues the patients have. In accordance with our study, Prieb, et al (2011) categorizes language barrier as the most commonly reported problem. This included interpreting services, risk of wrong diagnoses and misunderstanding, and selective translation when the translation is done by family members. In a similar study carried out by Michaelson, et al (2004) communication problems were one of the issues the health professionals mentioned. Teng, et al (2007) also mentioned language barrier issues as one of the main categories for the challenges the health care providers face.

## **6.10 Primary health check-up and interview**

Another important finding was that the first interview and health check-up taken by the nurse had an essential role in realizing the patient's medical and

disease history. However, it has happened that sometimes the asylum seekers had forgotten to talk about some diseases at the health interview or were scared because of some rumours in reception centres to disclose their medical history. This challenge is in line with the studies of Prebe et al. (2011) and Jensen et al. (2011) that mention the lack of medical history of the migrants.

### **6.11 Discussion summary**

Overall, the results of this study concur with results found in the study by Priebe et al., (2011). Similar identified problems are: cultural differences, lack of familiarity with health care system, language barriers, difficulties in arranging necessary care for migrants with no health care coverage, different understanding of illness and treatment, lack of access to medical history, negative attitude between healthcare workers and patients and social deprivation and traumatic experiences. Moreover, our results revealed that the cooperation of the nurses with other health centres and private services needed improvement. The training and guidance offered by the Migration office and Red Cross was in some cases inadequate. There was a very good level of support and cooperation between the nurses and other workers of the reception centres. The services of the interpreters played an important role on the diagnosis and treatment of the clients and it was exceptionally helpful when the interpreter used the same dialect as the patient and was as expressive as much as the client while translating. Finally, the use of the Red Cross uniforms was a reminder of the negative experiences of asylum seekers in other Red Cross centres in other countries.

### **6.12 Strengths and weaknesses of the study**

The limitations of these study were the small number of participants and that they were only from the extended Jyväskylä area. Therefore, the results cannot be generalized. Nevertheless, the usefulness of the results is left to the readers to decide if they can be applied to other Finnish or international recep-

tion centers. The strength of this study is that the information revealed and provided data where there was a gap in research and can be used by all related organizations for improvement of their services. Also, this study gave a chance for the nurses' experiences and opinions to be expressed, and for other nurses who are interested in working in this field to enrich their competences in order to offer high quality care to their clients.

As one of the interviewers mentioned based on experience: *"Independence, responsibility, knowledge and ability to find information are critical skills for this job. You should be mentally prepared to work here and have experience in nursing."*

### **6.13 Recommendations for future research and applications**

Future research on this topic can explore further the experiences of nurses in different reception centres of Finland which may add information to the present results. Additionally, a questionnaire can be developed based on current results and then delivered to all reception centres in Finland, in order to provide quantitative data. This way the generalizability will be increased to national level. Finally, a manual can be developed based on the findings, to be used by nurses entering the workforce in reception centres. This manual may include all derived challenges that nurses mentioned in this study and recommendations for best practice.

## **7 Conclusion**

Overall the results of this study suggest that the experiences of the nurses while working in the reception centres were affected by their past experiences and level of professionalism, the refugees own background, their cooperation with other services and translators and the support they received. Finally, the cultural differences between the nurses and the client affected the clients' ad-



aptation to the health care system, their treatment and care as well as the psychology of the nurses while dealing with the challenges.

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## 9 Appendices



## 9.1 Appendix 1

### Thesis confidentiality agreement

## 1 Contracting parties

Host Company / Organisation

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Representative of the Host Company / Organisation

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**JAMK University of Applied Sciences**

Head of Department

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Thesis tutor(s)

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Student(s)

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have today agreed on the following regarding the writing of the thesis:

### Topic of the Bachelor's Master's Thesis

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## 2 Confidentiality and the publicity of the thesis

JAMK University of Applied Sciences follows the recommendation of the Ministry of Education and Culture that theses should not contain confidential materials and that theses become public as soon as they are approved. Theses submitted for the assessment shall not include any business or professional secrets of the Host Company/Organisation; instead, those shall be put in appendices as the thesis background materials.

During the contractual relationship, the thesis tutor and student may not take advantage of or disclose to others any business or professional secrets of the Host Company/Organisation that have been entrusted to them or which they have become aware of *in conjunction with the thesis work*.

The Host Company/Organisation has the obligation to notify which of the information provided it wants to be treated as confidential. This must be clearly specified in the thesis. However, confidential information never includes information that (a) became common knowledge before the breach of contract, (b) the contracting parties or third parties have developed independently without a breach of contract by a contracting party, or (c) the Host Company/Organisation has given permission to publish or use.

The confidentiality of a thesis must always be justified and the duration for the confidentiality must be specified. The grounds for the confidentiality of the appendices to the thesis specified in this agreement (tick the box) The thesis contains:

- inventions, equipment or systems, tactical and technical methods and designs that serve the Defence Forces, the police, Customs and the Finnish Border Guard (*Act on the Openness of Government Activities* 24§, 5, 10)
- information relating to or affecting the realisation of the security arrangements of persons, buildings, installations, constructions, and data and communications systems (*Act on the Openness of Government Activities* 24§,7)
- information concerning preparations for accidents and emergency conditions, civil defence or its development (*Act on the Openness of Government Activities* 24§,8)
- information containing information on endangered animal or plant species or the protection of important natural habitats (*Act on the Openness of Government Activities* 24§, 14)
- information on any business or professional secret of the State, a municipality, some other public corporation or a corporation, institution or foundation (*Act on the Openness of Government Activities* 24§,17, 20)
- technological or other development project or assessment of the same (24§, 21)
- health information, including medical records (*Act on the Openness of Government Activities* 24§, 32; *Decree on medical records* 298/2009)
- information on the political convictions or the privately expressed views of a person, or information on a person's lifestyle, participation in voluntary associations or leisure-time activities, family life or other comparable personal circumstances of the person (*Act on the Openness of Government Activities* 24§, 32)  
(*Act on the Openness of Government Activities* (621/1999))

Based on other special legislation, please specify:

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Period of confidentiality:

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(one (1) year–25 years) from the thesis approval date

## **2.1 Confidential and privileged information**

The Host Company/Organisation shall undertake to provide guidance to help ensure that no confidential or privileged information is included in the thesis. An opportunity shall be reserved for a representative designated by the Host Company/Organisation to study the thesis no later than twenty (20) days before the intended submission of the thesis for assessment. The Host Company/Organisation has the right to demand revisions to the thesis if its publication might endanger patent application or other intellectual property rights protection of the Host Company/Organisation or if it contains confidential information of the Host Company/Organisation. A refusal must always be justified.

The student has a right to receive for revision any material that the Host Company/Organisation refuses to allow to be included in the thesis. The revision shall be done together with the Host Company/Organisation. The thesis shall be submitted for review once the sections detrimental interests of the Host Company/Organisation have been removed. If all confidential materials are removed from the thesis background materials, the thesis shall be completely public. If the Host Company/Organisation does not demand changes to the thesis within the specified period, the student shall have the right to submit the thesis for review as is.

## **2.2 Thesis presentation**

Thesis presentation is always public. The Host Company/Organisation and the student shall determine the presentation contents together to ensure that the presentation does not violate confidentiality.

## 2.3 Penalty

If the thesis tutor(s) or student(s) violate the aforementioned confidentiality obligation, the violation may lead to liability for damage. Indirect damage shall be excluded from the liability. Liability shall require an intentional breach of contract caused intentionally or through gross negligence.

## 3 Agreement validity

This confidentiality agreement shall enter into force upon being signed and shall be valid until \_\_\_/\_\_\_/\_\_\_\_\_ (dd/mm/yyyy).

This agreement has been prepared in three (3) identical copies, one (1) for each party.

## 4 Signatures

Place and date

Host Company / Organisation (signature and name in print)

Student (signature and name in print)

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Student (signature and name in print)

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Head of Department (signature and name in print)

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Thesis Tutor (signature and name in print)

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Thesis Tutor (signature and name in print)

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Language Tutor (signature and name in print)

Detailed instructions on the publicity of theses at JAMK

Host Company / Organisation

JAMK University of Applied Sciences

Student(s)

### **Detailed instructions on the publicity of theses at JAMK**

In accordance with Section 12.2 of *the Constitution of Finland (731/1999)*, documents and recordings in the possession of the authorities are public, unless their publication has, for compelling reasons, been specifically restricted by an Act. Everyone has the right of access to public documents and recordings.

A thesis written by a student at JAMK University of Applied Sciences is public. According to *JAMK's Degree Regulations*, Section 17: "It is not possible to write a completely confidential thesis at JAMK University of Applied

Sciences.” These must be available for public assessment. Publicity guarantees the objective and equal assessment of theses.

The publicity of a thesis can, however, be limited on specially decreed grounds.

According to Section 24 of *the Act on the Openness of Government Activities (621/1999)*, the following official documents shall be secret:

- inventions, equipment or systems, tactical and technical methods and designs that serve the Defence Forces, the police, Customs and the Finnish Border Guard (24§, 5 and 10)
- information relating to or affecting the realisation of the security arrangements of persons, buildings, installations, constructions, and data and communications systems (24§, 7)
- documents concerning preparations for accidents and emergency conditions, civil defence or its development (24§, 8)
- information containing information on endangered animal or plant species or the protection of important natural habitats (24§, 14)
- information on any business or professional secret of the State, a municipality, some other public corporation or a corporation, institution or foundation (24§, 17 and 20)
- A business secret is typically information that, if exposed, could cause financial losses for the company and financial advantage for its competitors. A business secret also covers skills connected to the abuse of the information based on business experience. A business secret may also be a technical secret. Documents only containing such information about the product that is directly revealed in the complete product do not qualify as business secrets.
- Professional secret refers to secrets that are more related to skill and often connected to the information acquired by an employee based on his/her profession. Professional secrets are often a necessary part of an employee’s activities.
- technological or other development project or assessment of the same (24§, 21)
- A technological development project may be connected to a product that can later be patented, for example.
- health information, including medical records (*Act on the Openness of Government Activities, Section 24§, 32; Decree on medical records 298/2009*)
- information on the political convictions or the privately expressed views of a person, or information on a person’s lifestyle, participation in voluntary associations or leisure-time activities, family life or other comparable personal circumstances of the person (24§, 32)

Confidential information must not be included in the actual thesis published; instead, they will be put in the thesis background materials. If the grounds for confidentiality are unclear, representatives of JAMK University of Applied Sciences must discuss the matter with the part financing the student’s thesis or the party whom the thesis is about, clearly justify the thesis publicity principles and the principles of legality connected to the confiden-

tial section. Similarly, the assessment of such a thesis must take into account the said party's desire for confidentiality and the party's account of the impact of the disclosure of the information.

If a student's thesis includes confidential background materials, a separate agreement must be drawn up regarding those materials. A thesis background material confidentiality agreement must be used between JAMK University of Applied Sciences, the company and the student(s) when agreeing on the confidentiality of the confidential background materials of a thesis. The agreement is signed by the Head of Department of the degree programme on behalf of JAMK University of Applied Sciences.

According to the Act on the Openness of Government Activities, confidential information must be marked clearly on the description page in the *Miscellaneous* section, clearly stating which sections of the document are confidential and what the confidentiality is based on (*Act on the Openness of Government Activities 621/1999, Section 25*). Legal grounds and a specified period of confidentiality must absolutely be stated for the confidential section of a thesis. The period of confidentiality is usually two (2) years but may be up to 25 years. Only based on special legislation may thesis sections, for example those including medical records, be made confidential for no less than 50–100 years. Confidentiality can never be agreed for perpetuity.

These instructions also apply to the working life development assignment included as a thesis in master's degrees.

The instructions have been approved by JAMK's Thesis Work Forum on 25 May 2016.

On behalf of

Mirja Nojonen

Hannu Ikonen



## 4.1 Appendix 2

### Possible questions

- ✓ Position in the center
- ✓ Main responsibilities
- ✓ How many residents and from where
- ✓ How long has she/he been working? where?
- ✓ What sort of expectation did you have before starting this job?
- ✓ Cultural differences nurse vs refugee
  - Concept of pain – overreaction
  - Not understanding the concept of medication
  - Not understanding the concept of nurse's role
- ✓ Different understanding of illness and treatment
  - Difficulty understanding basic body anatomy and how its functions (health literacy)
  - Illiteracy or cultural/religious biases?
- ✓ Unfamiliarity with health care system
- ✓ lack of access to medical history
- ✓ Social deprivation and traumatic experiences
  - Mental health literacy – difficulties in realizing/understanding/accepting the existence of mental health issues
- ✓ Stigma and discrimination from society, other members or from staff?
- ✓ Language barrier

- Interpreter issues? Eg. Confidentiality issues between same community interpreter
- Wrong diagnosis/treatment because of selective translation/misunderstanding if family member is a translator.
- ✓ Migrants with no health care coverage – have you had any such a case? If yes, what kind? Ex. Negative asylum seeking decision
- ✓ if you had any case of authorities' involvement and if this was a barrier in providing care.
- ✓ negative attitude between healthcare workers and patients
  - have you faced any?