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Focus group qualitative analysis of Middle East and Western nurses assessing and planning interventions in refugee camps

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Abstract

Aim: This paper is a focus group Qualitative analysis of nursing perception of refugee needs.

Background: Receiving quality health care is a challenge for refugee populations as often live in crowded, unsanitary conditions. The International Council of Nurses' Code of Ethics asserts that nurses should expand beyond the individual model and promote a rights-enabling environment where respect for human dignity is paramount.

Introduction: This investigation is analysis of Middle East and Western nurses' collaboration in assessing and planning an intervention in refugee camps. Our education policy should be to prepare our future nurses for any health challenge they may face. Working with refugees and displaced people is currently a global health care challenge.

Methods: During an international nursing conference focusing on nursing force in promoting health equity, participants were asked to recognize influence of social health determinants of refugee individuals and populations. Second, identify barriers to health care. Third, discuss professional roles in refugee patient/client care. Finally, demonstrate inter-professional engagement. The participants were from diverse populations and many of them defined themselves as displaced persons or refugees.

Findings: A total of 135 nurses, midwives, nursing managers, students and professors from 12 countries participated in focus groups. Central themes included Basic human needs, management, healthcare, and communication.

Conclusions: When nurses face unfamiliar situations, they use fundamental nursing theories, Watson caring theory, & Maslow to structure their assessment, intervention and evaluation.

Social Policy: When theory developing policies for refugee care, knowledge and practice of fundamentals of nursing is paramount.

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Introduction

The Syrian refugee migration is one of the largest humanitarian crises in recent history [1]. We need to prepare our health care system to provide services for the influx of refugees. Before and during the migration journey, many refugees experience hardships and stressful life events, including conflict-related violence, loss of family members, exploitation, injuries and poor nutrition, that put them at risk for physical and mental health problems [2,3].

The United Nations defines a refugee as "a person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country [4]. Refugees, unlike immigrants, leave their home countries under immediate threat of persecution. Many refugees suffer from undiagnosed illnesses such as heart disease or hypertension, post-traumatic stress disorder (PTSD), diabetes, or malaria [4]. It has been claimed that humanitarian and aid agencies speak on behalf of the refugees and deny the refugee to speak for themselves [5]. As a result, health interventions in refugee camps are often not suitable or appropriately planned, financed or implemented in an efficient or collaborative way [6].

Refugee camps are defined as crucial spaces for working out refugee identity and claims. The meanings ascribed to camps shape relations among various actors in these spaces. The humanitarian, political, and emotional aspects of camps all impact refugee lives. Camps are sites for the articulation of arguments about what constitutes a legitimate refugee life. In a study reported by *Medecin Sans Frontieres*, workers from five internal displacement camps in the Democratic Republic of the Congo (DRC), found the main causes of death to be malnutrition, suspected malaria, infections, and diarrheal diseases [7]. They also noted 45.3% of refugees were unvaccinated for TB and 68.5%

were unvaccinated for measles. The ability to provide healthcare services within these camps was minimal. When refugees fell ill in the camps, the majority did not seek care from the local health care system due to the cost of consultation and the cost of medicine [6] but rather remained untreated.

In a study of 12,000 internally displaced persons, [8] found extremely poor sanitary conditions and high population density with war related violence or murder the most frequently reported cause of death for those over 5 years old. Fifty-three percent of families reported at least one violent event involving a family member within 100 prior days prior to the survey. Because of the inability to issue a death certificate, families were left without legal confirmation of a family member's death [8]. Receiving quality health care is a challenge for refugee populations as they are often living in crowded, unsanitary conditions. In a study conducted at refugee camps with 816 participants from three countries, Uganda, DRC, and Yemen, Whelan and Blogg [9] found a major concern of the refugees was the treatment they received from local hospital personnel. Participants felt discriminated against by staff and believed the care they received was sub-standard [8]. In a systematic review of the literature, reported on the complex health needs exhibited by displaced persons. The services required are considerable - ranging from mental health services to transportation to receiving quality, affordable health care [10].

The International Council of Nurses' Code of Ethics asserts that nurses should expand beyond the individual model and promote a rights-enabling environment where respect for human dignity is paramount [11]. A study in Canada found nurses need to promote refugee families' health in cultural transition, by establishing a holistic approach. Such an approach demands that nurses cooperate with other health care professionals and community authorities, and practice family-focused nursing; it also demands skills in intercultural communication

paired with cultural self-awareness in interacting with these families. Adequate knowledge regarding these skills should therefore be included in the education of nurses, both at under- and at post-graduate level [12]. Knowledge of this unique population is integral to healthcare professionals who encounter refugees in practice. Regardless of the specific group, access to healthcare services must be determined for better health outcomes. The following investigation is an analysis of nurses from Middle East and Western countries collaboration in assessing and intervention in refugee camps. The aim of this study is a Qualitative analysis of nursing perception of refugee needs.

Theoretical framework

Nursing knowledge includes the patient as well as the environment of care. In recent years, health care has been championed as a “bridge for peace” (World Health Organization; Health as bridge for peace. 2009) with the potential to reduce conflict through a variety of interventions. Fundamentals in nursing bases its theory on the generalization care (empathy) delivery, and that in every clinical setting, hospital, community or home-based nurse’s health interventions are founded on the theory of empathetic caring.

Nursing values, ethic, philosophy, knowledge, and practices of human caring require language order, structure, and clarity of concepts and worldview underlying nursing as a distinct discipline and profession [13]. The theory goes beyond the dominant physical worldview and opens to subjective, inter-subjective, and inner meaning, underlying healing processes and the life world of the experiencing person [14]. Using Watsons' caring theory is the founding motivation of the Middle East nurse’s non-profit organization in their investigation of health care delivery to refugees. Caring science as a model for nursing allows nursing’s caring–healing core to become both discipline-specific and transdisciplinary. Thus, nursing’s timeless, ancient, enduring, and most noble contributions

come of age through a caring-science orientation-scientifically, esthetically, and ethically [14].

Methodology: sample, data collection, data analysis

Due to the lack of research regarding nursing perception of refugee needs, qualitative research methods using focus groups were deemed to be the most appropriate for the research [15]. When it comes to investigating perceptions in qualitative research, individual or focus group interviews are the best method of investigation [16-20]. A focus group design was selected to allow the principle investigators to effectively address the research foci with semi-structured, open-ended questions that were concerned with understanding how the initial assessment should be done by nurses in refugee encampment. The openness of focus groups also allowed for similarities and differences among participants’ experiences and perspectives to emerge from group discussions [21], leading to the establishment of a foundation of literature on this topic providing future researchers with valuable insight into the nursing perception of refugee needs. Focus group was conducted during international nursing conference sponsored by Watson Caring Science Institute involving 135 participants from different nationalities divided into seven mixed groups. The moderator provided presentation and imaginary scenario describing a fictionally country at civil war.

The scenario was described to focus group participants "Near the border, after the conflict with Sernai 30500 refugee run into Antegria". The moderator provided the following factors to build a framework for nurses to assess common health needs among the refugee population.

1. First, recognize the influence of social determinants of health of refugee individuals and populations.
2. Second, identify barriers to health care in refugee populations. Third, discuss

professional roles in refugee patient/client care.

3. Thirdly demonstrate inter-professional engagement.
4. Present a cohesive team plan priority establishing health centers, disease control, community restoration and leadership.

Ten groups of 10-15 participants were then given 20 minutes for cohesive work and brainstorming, then each group presented their work using flip chart board paper (figure 1).

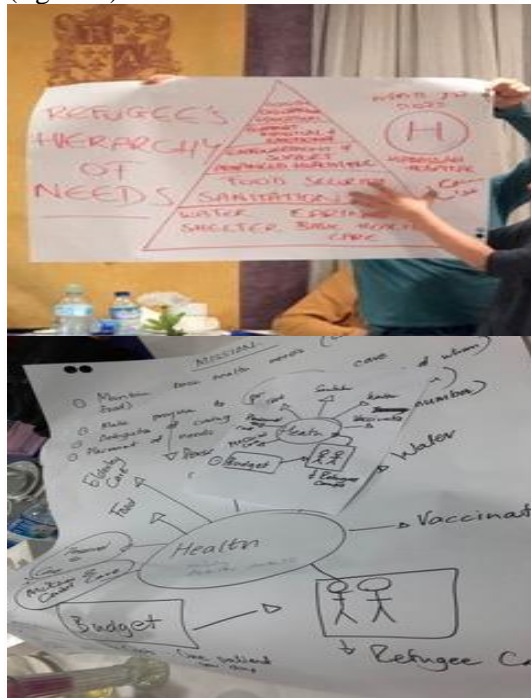


Figure 1: example of flip chart board paper of focus group

After each group presented their plan, open discussion with entire 135 participants ensued to clarify depth of perception and clarification. During these presentations, videotaping was preformed, after asking consent. The tapes are confidentially stored. The tapes were solely used for data interpretation and analysis. Researchers asked permission of conference attendees to analysis data.

The researchers then considered confirmation of the credibility and conformability of the study. Conformability of findings means that the data accurately represent the information that the participants provided. The interpretation of this data is not an invention of the inquirer [15]. In this study, interestingly, the researchers analyzed flip chart paper which was written in three languages, Arabic, English, and Hebrew. In addition to flipchart, the videotapes of focus groups were viewed, so that the investigators could gain a deeper understanding of the quotes and participant perceptions. Using thematic analysis to ensure credibility of analysis, one researcher fluent in English and Arabic, other fluent in Hebrew and English. Working as a team throughout the research process covering all cultural, linguists' challenges and ensuring rigorous data analysis. As well as keeping the systematic work and reflexivity of researcher throughout the study.

Ethical considerations

The study was conducted according to the principles of the Declaration of Helsinki (WMA, 2013). The study does not fall under the provisions of the Act on Medical and Health Research in Norwegian legislation, since it does not generate new knowledge about health and disease or use human biological material. Study participants were informed of the aims, methods, conflicts of interest, institutional affiliations of the researcher, and the anticipated benefits and potential risks of the study and the discomfort it may entail. The participants were informed of their right to refuse to participate in the study or to withdraw consent to participate at any time without reprisal. Study participants gave verbal informed consent. Polit and Beck [16], argue for the use of quotations that indicate the trustworthiness of results. It is impossible to evaluate how the results have been created and their trustworthiness without full description of analysis process [22]. Therefore, the full description of data using quotations from participants are presented in next section.

Results & Discussion

135 participants were nurses, midwives, nursing managers, students and professors presented many countries in the world as seen (Table 1). They are working in hospital, community, university, Ministry of Health,

Non-Government organizations and World Health Organization. All participants consented to participate in this study. The participants were randomly divided into 7 focus groups average 15 in each group.

Table 1: Demographics of the focus groups participants.

Employment	#	Country	#
Community health	5	Jordan	3
General hospital	71		
Mental Health hospital	10	Australia	1
Ministry of Health	2	Iraq	1
NGOs	7	Israel	64
University or College	23	Palestine	53
WHO	2	Norway	2
		Saudi Arabia	4
		South Africa	4
		Tunisia	1
		UAE	1
		Switzerland	2
		USA	11

Using thematic analysis four major themes and 112 codes emerged from participants, perceived that nurses work in multi-faceted prioritize- initial, short term and longer term. In addition, clarifying prioritizing of needs. The four themes were: 1st stage priority Basic life that includes 33 codes; management includes 2 codes; Healthcare 52 and communication 8 codes (Table 2).

Table 2: Theme, subtheme and code of data analyses

Theme	subthemes	codes
1- Basic human needs	1.1 Maslow hierarchy 1.2 Essential Materials	33
2- Management	2.1 Organization 2.2 Budget	20
3- Healthcare needs	3.1 Adult 3.2 Pediatrics 3.3 Maternal 3.4 Animal care	52
4- Communication	4.1 News & information media internet 4.2 Documentation 4.3 Translators 4.4 Integration	8

“Basic human needs” – Maslow's Hierarchy of Human Needs

The participants perceived this theme as priority in caring of refugee based on Maslow's Hierarchy of Human Needs [23,24]. This is not surprising based on their theoretical background as nurses. It is mentioned in all seven groups and divided into two subthemes Maslow hierarchy and needs of essential material. The participants used MASLOW hierarchy to emphasize and structure their care assessment categories that include: need of water, sanitation (water purification & sewage system), food-nutrition, shelter suitable for area where encampment is geographically situated (sleep, mattresses, free from insects, building materials) heating, or shelter with ventilation. All of these were seen by participants as an essential aspect to survive.

Maslow [23], suggested that the first and most basic need people have is the need for survival: their physiological requirements for food, water, and shelter. People must have food to eat, water to drink, and a place to call home before they can think about anything else. If any of these physiological necessities is absent, people are inspired to meet the missing need [23,24]. Participants of FG in current study highlighted this issue. As we look at the refugees, fleeing their home country and transferring to another place that they considered safer from their point of view. After their physiological needs have been met, refugee can work to meet their needs for safety and security. Safety is the feeling of no harm will befall them, physically, mentally, or emotionally, while security is the feeling that fears, and anxieties are low. After the physiological needs and the needs for survival and for safety and security have been met, an individual will then strive to meet the needs represented at higher levels of the pyramid. The third level of the pyramid is love and belonging. Having satisfied their physiological and security needs, people can venture out and seek relationships from which their need for love and

belonging can be met. However, for refugee needs will stop in third level of pyramid. Being a refugee considered as disaster for them. One participant with previous experience working with refugees after environmental disaster said *"As a nurse I was the only person who switched off the lights, give everyone a blanket and said, "everyone to bed it is time to sleep now"* (FG #1) this quote was chosen to reflect the importance this nurse demonstrated in restoration of routine, and sense of security.

One participant working as a doctor emphasize the role of nurses and their comprehensive view in emergency, he said while laughing:

"we must differentiate between medicine and health- " medicine is free from disease and identifying a pathogen. However, health is nursing dealing with wellbeing illness prevention" (FG #2) This quote reflects that nurses develop plans and create infrastructure for communities to grow and they do not always seek to solve only 'health' problems. It is not astonishing as nurses to use Maslow hierarchy in the first stage of dealing with refugee people. As first part was completed the participants suggested to work with the next theme.

Essential materials were considered the second part of priority from participants perspective. The materials include availability of laundry facilities, personal hygiene, toothbrushes blanket, toys, pesticides, books, safety- violence protection, animal bites protection and personal belongings. One participant said

"as nurses we think about basic life needs according to MASLOW hierarchy- as soon as these needs are assessed, and solutions are found we proceed to the next level of need" (FG # 7). Nurses turned to Maslow's hierarchy of needs, one of the first theories taught in nursing school, which puts forward that people are motivated by five basic categories of needs: physiological, safety, love, esteem, and self-actualization.

Management

This theme includes 2 sub categories and 20 codes. The abuse of power, sexual or other, the hijacking of food rations, the creation of networks of clandestine workers are the normal, daily lot in the majority of refugee and displaced persons camps found in Africa [25]. Therefore, a biopolitical management system needs to be developed to establish everydayness of life in camps, focusing on organization of screening, and assignment of residents in space and according to categories, and the division of labor among NGOs on site [24].

Organization- Tasks needing immediate attention include delegating chores and functions, organizing shelter areas in a map and addresses in order to find people, organizing local leadership community center (spiritual center, educational center, sport activities) Staffing to enable around the clock multi-disciplinary teams working (nurses, midwife, doctor, medic, social worker, dentist, veterinarian, security police, electrical and water and sewage, specialist). In fulfilling staffing requirements, a search from local hospitals, overseas volunteers through NGOs and foreign government requests. Another recommendation was to develop a self-independent farm with donated seeds, tending to farm animals chicken cows.

Group # 4 "staffing according to volume of need.

Pregnant women group, 8 nurses per shift for adult care, 15 nurses for pediatric care" *"To prioritize care we have to focus on delegation of who takes care of whom- using healthy refugees to care for young children while providing them with instruction and training". In addition to prioritization of care, separate male and female tents – culturally sensitive" assuming that refugees are from Muslim background- also preventing gender violence"*(FG#2)

Budget- One of the many challenges found in past refugee camps is that there is 'a silencing of refugee voices by aid agencies, government bodies, and other groups claiming to work on their behalf without giving refugees the opportunity to speak for themselves.' As a result, interventions in refugee communities are often not planned, financed, or implemented inefficient, dignified, and collaborative ways [26]. Nurses in the focus groups suggested documenting desires and opinions of camp members on questions of governance, budget prioritization and other socio-economic conditions.

There is a need to calculate costs of essentials according to per person per day per age - prioritize the budget- according to basic needs. All budgets requirements should be organized collaborated between NGOs and local and foreign governments, and EU grants.

"one of the nursing basic tools is the skill in taking intake and assessment of people, listening to what they are truly saying and the ability to be flexible with needs, perspectives and available resources" (FG #7)

Under this theme, four subthemes with 52 codes were presented. Campbell et al. [27], proposed that understanding the refugee's experience of and access to healthcare are important factors for improving and promoting health. Refugees are suffering from poor mental and physical health compared with the host country population. This could put them at a greater risk of morbidity and mortality disease [28].

Therefore, it is not surprising that healthcare received the largest number of codes. Most of participants mentioned that adult care was important and should include the availability of medication especially for chronic disease to prevent complication, mental health (PTSD assessment and early intervention), support and empowering their needs, fight infection by hygiene instruction, follow up chronic diseases, prevent health crisis- epidemic by early

identification of people at risk. Every refugee undergoes initial assessment at health care clinic. If necessary special tent or shelter can be created for infected persons.

"Many of refugee might have already chronic disease like diabetes or hypertension in his/her country, so as early as possible measuring blood pressure, blood sugar and control blood glucose is life threatening for him/her" (FG#2). Many previous studies agreed that general health of refugee need more attention [29];

Many refugees undergo both physical and psychological stress, which can increase their risk of developing mental health problems during the transition to and upon arrival in the host country. Depression and posttraumatic stress disorder (PTSD) are most associated mental problem with refugees [30]. In a qualitative study done with Iraqi refugee women in the United States, the women expressed and complained about poor physical health, anxiety, stomach pain, psychological discomfort, thyroid disease, chronic disease and other physical and psychological health issues [31]. Taylor et al. [32], performed a US survey and found that among newly arrived adult Iraqi immigrant's chronic health conditions such as high cholesterol, hypertension, overweight/obesity and diabetes were reported. Approximately 60% reported to have at least one chronic condition, while 37% reported having at least two chronic conditions. The prevalence of anxiety, depression and emotional stress was nearly 50% among the participants, and 31% were identified as having PTSD.

Pediatrics/ children was the second subtheme. Participants considered children, women and geriatric as vulnerable groups needing special care and priority. The care of these children should include monitoring for dehydration, giving vaccinations, growth and development surveillance, providing baby food or milk, and diapers. The third subtheme was maternal care including prenatal-post natal care, mother child clinic, breast feeding instruction and support,

birth control-contraceptive and helping mother during labor close monitoring and instructions. Others suggest cultivating domestic animal and farm life.

One of participant suggested the following *"for effective use of human resources. We can use well healthy women in helping others. We can use mothers with previous experience with child bearing and delivery to assist pregnant women in active labor and so on"* (FG#4).

Participants in previous quote highlighted important issue that women should care of women and respect privacy. Many studies highlighted the importance in providing refugees with culturally appropriate healthcare services [33-35]. Cultural competence is viewed as an essential component for providing relevant, effective and culturally responsive healthcare services [36].

Communication

News & information media internet- refugees evacuated from their homes use various media, and especially the internet, to keep in touch, receive and disseminate information and express their opinions. Lev-On 2011 found that refugees use assortment and variety of media, according to need. Lev-On demonstrated how media usage assists in establishing and maintaining a sense of community after the forced transition from the communities of origin. Media can address a few types of needs, such as cognitive (information and understanding), affective (emotional and aesthetic experiences), escapist (disconnect from reality) and integrative (strengthening the sense of belonging and relationships with family/friends/ community/state, as well as providing for a sense of security, trust, stability and status) [37,38].

Documentation - unlike other immigrants, many refugees arrive with no documentation of immunization. Meropol found that only 39% of a predominantly Vietnamese refugee population had evidence of adequate

Immunization [39,40]. Orderly and methodical registration of refugee inhabitants is necessary to supply systematic provisions. Registration is defined very broadly as 'the act of producing a written record' commonly involving a production of lists [41]. Documents can be 'enabling as well as subordinating' and confer 'rights as well as police powers'.

"documentation- every refugee name and family and address of tent and medical problems- medical file" (FG# 7).

Translators- first priority should be to employee health care providers who speak the same language as the refugee populations. All efforts should be made to search for nurses who not only speak the same language but also understand the same culture as the refugees. The Sastre et al. [42], study found barriers to obtaining quality care consistently included barriers of language, culture and medical staff attitudes. Resources such as help lines were often perceived as ineffective because clients could not always make their requests in English or indicate the language needed [42].

"We need translators- cultural competent to build trustworthy relationship based on understanding - relief barrier of communication (FG #5).

Integration into local community- recent evidence from Europe and elsewhere demonstrates a prevailing notion of nationhood and citizenship establish considerations of integration and argue that local integration shapes the social incorporation of refugees regarding 'belonging' [43,44]. Integration is a 'two way' process, suggesting how social belonging be expanded to contain the diversity and suppleness of social meaning and identity [45]. The nurse participants found that social local integration was essential to develop good relationships with outside world and local community" *we build many walls without enough bridges"* (FG#6)

Implications for Nursing & Health Policy

Our study reflects that regardless of the specific group, access to healthcare services must be determined by policy driven by nurses to insure better health outcomes. When developing such policies for refugee care, knowledge and practice of fundamentals of nursing is paramount.

Study Strengths & limitations

There are many strengths for the current study. First, participants in groups and researchers in current study originated from cultural diversity similar to current refugees' status establishing a familiarity with culture. Mentality, nurses from different background hold varied experience with working with refugees. Many nurses working in refugees' atmosphere many consider themselves refugees, Jordanians working with Syrian refugees. Second, the participants in the conference are highly motivated to make social impact open to understanding other cultures. Third, the most exposed health care individual caring for refugees are nurses. Fourth, increased awareness among conference participants on need for nurses to work with refugees. In addition, these participants can influence budget and resource allocation toward refugee status. Another strength that data analysis was done by viewing video tapes of focus group presentations of their assessments in addition to written flipcharts. The videotape allowed the investigators to deeply interpret the nonverbal messages of the participants. A limitation is that this work was performed during a nursing conference reflecting that the participants may not be a representative sampling of all nurses.

Summary and Recommendations

Basic Human needs is obviously clear that nurse's perceptions were focused on using Maslow hierarchy in assessment and intervention of refugees needs. To request budget for enough materials essential and fundamental materials like toilets, water etc.

When nurses are faced with unfamiliar situations, they use their fundamental nursing theories such as Watson caring theory, Maslow to structure their assessment, intervention and evaluation. We recommend that cultural competency should be mandated in educating nurses to delivery appropriate effective relevant health care services and equity in health.

Declaration of interests the authors declare that they have no conflict of interests or financial disclosures.

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