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Experiences of Healthcare Professionals Providing Women's Health Services to Asylum Seeking Women at the Hospitals

Hastanelerde Sığınmacı Kadınlara Kadın Sağlığı Hizmeti Sunan Sağlık Profesyonellerinin Deneyimleri

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ABSTRACT

Objective: This study aimed to describe the experiences of healthcare professionals providing women's health services to asylum seeking women at hospitals.

Methods: A qualitative design was used in this study. The data were collected from thirty-four healthcare professionals providing women's healthcare services to asylum seeking women through semi-structured, face-to-face, individual in-depth interviews. The data were evaluated using Colaizzi's seven-step analysis method in the NVivo12 package program.

Results: Three themes were identified (1) challenges, (2) reflections, and (3) needs. Healthcare professionals evaluated the process of providing women's healthcare services to asylum seeking women from a positive and negative point of view. They stated that they should be supported personally, professionally, and as a health team in improving this experience.

Conclusion: This study narrows the gap in the literature and expands the scope of existing knowledge concerning the healthcare professionals experience about asylum seeking women health care.

Keywords: Asylum seekers, qualitative research, women's health

ÖZ

Amaç: Bu araştırma, hastanelerde sığınmacı kadınlara sağlık hizmeti veren sağlık profesyonellerinin deneyimlerini tanımlamayı amaçlamıştır.

Yöntemler: Araştırmada nitel araştırma tasarımı kullanılmıştır. Veriler, yarı yapılandırılmış, yüz yüze, bireysel derinlemesine görüşmeler yoluyla sığınmacı kadınlara kadın sağlığı hizmeti veren otuz dört sağlık profesyonelinden toplanmıştır. Veriler, NVivo12 paket programında Colaizzi'nin yedi aşamalı analiz yöntemi kullanılarak değerlendirilmiştir.

Bulgular: Araştırma sonucunda (1) zorluklar, (2) yansımalar ve (3) ihtiyaçlar olmak üzere üç tema belirlenmiştir. Sağlık Profesyonelleri, sığınmacı kadınlara kadın sağlığı hizmeti sunma sürecini olumlu ve olumsuz bir bakış açısıyla değerlendirmiştir. Bu deneyimin geliştirilmesinde kişisel, mesleki ve sağlık ekibi olarak desteklenmeleri gerektiğini belirtmişlerdir.

Sonuç: Araştırmanın sonuçları, literatürdeki boşluğu daraltmakta, sağlık çalışanlarının sığınmacı kadın sağlığı hizmetlerine ilişkin deneyimlerinin anlaşılmasına yardımcı olmakta ve bu deneyimlere ilişkin mevcut bilgilerin kapsamını genişletmektedir.

Anahtar Sözcükler: Kadın sağlığı, nitel araştırma, sığınmacılar

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Introduction

One of the top priorities of the United Nations Sustainable Development Goals 2030 is to reduce inequalities within and between countries for disadvantaged populations. The basis of this goal is the necessity of accepting health as the most basic human right, regardless of the gender, race, religion, social class and political orientation of the individual (1). Despite all regulations in the world and Turkey, it is reported that especially women who migrate experience barriers to accessing this right. When these barriers to accessing the service are evaluated holistically, the individual characteristics of asylum seekers, the health system, health policies, the geographical location of the country, and cultural social factors and discrimination are emphasized (2). Studies trying to explain migration from the perspective of asylum seeking women benefiting from health services have focused on asylum seeking women's health problems, prenatal and postnatal care experiences, migration experiences and the effects of migration on women's health (3,4). Studies on the effects of migration on women's health focused on maternal health and emphasized that the access of pregnant women who migrated to antenatal care was often delayed (5,6). Additionally, these studies focused on the negative experiences of asylum seeking women during their pregnancy (7,8).

When evaluated in terms of health care providers to asylum seeking women, it is quite difficult to provide adequate and culturally appropriate gynecological and obstetric health care services to minority ethnic groups. In order to overcome this difficulty, it is imperative to examine and understand the views of health professionals on the care of asylum seeking women. So far, research in this perspective has focused on the barriers healthcare professionals face in providing services. These obstacles are; inability to coordinate care, cope with cultural diversity, and communication barriers (9-11). Studies generally focused on communication barriers, were carried out with a single group of health professionals or were carried out in a descriptive design. However, a multidisciplinary perspective and qualitative design are very important in revealing the experiences of health professionals holistically.

This study aimed to describe the experiences of healthcare professionals providing women's health services to asylum seeking women. The results of the study, which examines the experience of providing women's health to asylum-seeking women from a multidisciplinary perspective, present the process not only in terms of obstacles, but also in a broader framework. It is thought that it will contribute to the development of women's health services, especially in the regions where refugee women live and in the hospitals they are admitted to.

Methods

Study Design, Participants, and Setting

This study aimed to phenomenologically describe the working experiences of doctors, nurses, and midwives health care for asylum seeking women through a qualitative design. A snowball sampling method was used. The inclusion criteria for this study were (a) being a nurse, a midwife, or obstetricians and gynecologists working on the frontline, (b) providing women's health care services to asylum seeking women and working at obstetric and gynecology service and delivery room (c) having more than six months of experience. Other healthcare professionals who had less than six months of experience were excluded. Following the literature for phenomenological studies, the absence of new information in the interviews was accepted as an indicator of data saturation (12). The study was completed with 34 healthcare professionals (12 nurses, 15 midwives, and 7 physicians). This study was carried out in four state hospitals, each with a capacity of 150 beds, located in the border districts of Şanlıurfa, where temporary accommodation centers were located, and a training and research hospital with 500 beds in the city center.

Ethical Considerations

Approval was obtained from the Istanbul University Social Sciences and Humanities Research Ethics Committee to conduct the study (date: 26.06.2018, number: 66934). The participants were provided with necessary explanations about the study (objective, content, and the data obtained would be used only within the context of this study; they had the right to leave the study). Consent was obtained from the participants who agreed to participate in the study. The participants were given a number, and data confidentiality and anonymity were ensured. The data obtained from the interviews were kept in encrypted files that only the researchers could access. This study was carried out in line with the Declaration of Helsinki, 1964.

Interview Guide

Following the objective and question of this study, a semi-structured interview guide, which was prepared with support from the literature, was used (3,13,14). Two experts on qualitative research methods evaluated the interview guide, and the questions were tested with two pilot interviews. The required revisions were made following expert views and pilot interviews, and the interview guide was finalized (Table 1).

Data Collection

The semi-structured, face-to-face and individual in-depth interview methods were used to collect data. The first participant who met the inclusion criteria in the study was reached by contacting the managers of hospitals and the other potential participants were determined in line with snowball sampling. The participants were informed about the study's aim, scope,

Table 1. Key questions

What are the women's health services provided to Syrian migrant women?
What problems do you encounter in this process?
How do you spend a working day in this hospital/in your unit?
How do you feel when you leave the hospital/your unit at the end of the day?
Could you tell us about an incident that you experienced with Syrian migrant women that affected you and left a trace on you?

and process. Interview time and place were determined by the participants who agreed to participate in the study. The first researcher conducted the interviews, and each was recorded with a voice recorder with the participant's consent. The duration of the interviews varied between 32 and 53 minutes (41 minutes on average). In this study, data collection and analysis processes were conducted in parallel, and a codebook was created to help determine the time to reach data saturation. In the 34th interview of the study, it was decided that data saturation was reached. There weren't repeat interviews carried out. The interviews were carried out between January 2019 and April 2019. All researchers on the research team were academics in nursing and had Ph.D. degrees, and they were female.

Statistical Analysis

In analyzing the data obtained from the study, Nvivo 12 software package and (15) Colaizzi's seven-step method (1978) were used (Table 2). Within the scope of trustworthiness, this study tried to meet four criteria: credibility, transferability, dependability, and confirmability (16). In this context, the NVivo12 software package used to analyze the data ensured credibility. The researchers discussed the confirmation of the participants, the process of the research through frequent meetings, and the inclusion of the qualifications of the researchers in the text. The research sample, environment, and process were presented clearly and precisely to ensure transferability. Statements of the participants were directly quoted in the text. For reliability, the researchers created the codes and themes using Colaizzi's seven-step method (15). An expert outside the research evaluated the consistency between the researchers and the suitability of codes and themes, and the results were validated. Different researchers coded data to ensure confirmability. Lastly, the consolidated criteria for reporting qualitative research checklist was followed in reporting (17).

Results

In the study group, 30 of the 34 healthcare professionals were females, and their ages varied between 23 and 48. Twelve participants were nurses, 15 were midwives, and 7 were obstetricians and gynecologists. While the participants' experiences in their current institution varied between 6 months and 11 years, their total experience varied between 6 months and 30 years. Thirteen of the participants were married. All participants worked in the gynecology/obstetric units (Table 3).

As a result of data analysis, reached the three main themes: (1) Challenges, (2) reflections, and (3) needs. Table 4 shows each theme's sub-themes, codes, and example quotations.

Discussion

The experience of caring for asylum seeking women is full of uncertainties and obstacles. The risk of experiencing these problems will continue due to rapid changes in world dynamics and forced migration movements. This study aimed to describe the working experiences of doctors, nurses, and midwives in health care for asylum seeking women through a qualitative design.

Discussion section is presented by discussing under each theme.

Challenges

According to the participants, the physical structure of the hospital they worked in and the equipment when providing women's healthcare services to asylum seeking women was

Table 2. Colaizzi's seven-step method

	How it was used in the study
1st step: Understanding the general meaning of transcribed texts	The interviews were recorded with a voice recorder and they were backed up. The interviews were transcribed and a 132-page document was created. The consistency between the records and written documents was read and checked by GTU and U.B. by reading a number of times. All interviews were listened to three times and read six times.
2nd step: Finding out all meaningful expressions in transcriptions	The two researchers collected meaningful expressions from the transcriptions independently and formed a table. 34 important quotations. The quotations were recorded with participant code, line and page numbers.
3rd step: Formulating the meanings of meaningful quotations	Codes were assigned to expressions and comprehensive code book was prepared. Following this, the similarities and differences between the expressions defined by independent coders were discussed until the research team reached a consensus.
4th step: Organizing the codes created from formed meanings into themes and sub-themes	The relationships between the codes obtained from the data were evaluated and sub-themes and themes were categorized. The researchers discussed on the codes until they reached a consensus and the codes were classified under 9 sub-themes and 3 themes.
5th step: Making a comprehensive explanation of the studied phenomenon **6th step:** Describing the basic structure of the phenomenon	A comprehensive description (5) and basic structure (6) of the phenomenon were created.
7th step: Feedback to the participants	The codes and themes were sent to three randomly chosen participants with the interview transcripts to evaluate the relevance of the findings and feedback was received.

insufficient. The participants emphasized that they had problems, especially with the delivery room, operating room, inpatient units, blood bank, and neonatal intensive care unit, and beds were insufficient for the patients referred to the hospital. Another study conducted in Turkey stated that almost half of the healthcare services in public hospitals in cities close to the Syrian border experienced capacity problems in terms of physical conditions and healthcare professionals because of the services provided to asylum seekers (18). Other causes of the problems are that most asylum seekers ignore the chain of referrals and refer to hospitals by skipping primary healthcare centers due to insufficient resources, equipment, and beds (19). Asylum seekers receiving health services in Sweden, on the other hand, expressed their dissatisfaction with emergency services (20). This information can be considered as an indication that hospitals are not ready for the dense population of asylum seeking patients with different health backgrounds.

The participants emphasized negative working conditions as an essential source of problems experienced when providing women's

Table 3. Socio-demographic characteristics of participant

Participant	Gender	Age	Marital status	Education background	Profession	Experiences of current institution (year)	Total experience (year)
1	Female	26	Single	Bachelor	Midwife	2	2
2	Female	30	Single	Bachelor	Nurse	5	6
3	Female	25	Single	Bachelor	Midwife	1	2
4	Female	26	Single	Bachelor	Midwife	2	4
5	Female	26	Single	Bachelor	Midwife	1	1
6	Female	26	Single	Bachelor	Nurse	1	1
7	Female	24	Single	Bachelor	Midwife	1	1
8	Female	23	Single	Bachelor	Midwife	1	1
9	Female	26	Married	Bachelor	Nurse	1.5	3
10	Female	25	Married	Bachelor	Nurse	1	4.5
11	Female	25	Single	Bachelor	Nurse	1	3
12	Female	23	Single	Bachelor	Nurse	1	1
13	Male	40	Married	Higher degrees	Doctor	3	10 l
14	Female	30	Married	Bachelor	Midwife	11	18
15	Female	28	Single	Bachelor	Midwife	1.5	8
16	Female	31	Married	Bachelor	Midwife	5	7
17	Female	32	Married	Bachelor	Nurse	3	10
18	Male	30	Married	Higher degrees	Doctor	1	5
19	Female	30	Single	Bachelor	Midwife	1.5	3
20	Female	24	Single	Bachelor	Nurse	1	1
21	Female	27	Married	Higher degrees	Doctor	1	5
22	Female	40	Married	Bachelor	Midwife	1.5	20
23	Female	48	Married	Bachelor	Midwife	1	30
24	Male	32	Married	Higher degrees	Doctor	1	3
25	Female	27	Single	Bachelor	Nurse	3	6
26	Female	30	Single	Higher degrees	Doctor	1	7
27	Male	31	Single	Higher degrees	Doctor	1	5
28	Female	24	Married	Bachelor	Nurse	2	2
29	Female	29	Single	Bachelor	Midwife	9	9
30	Female	28	Single	Bachelor	Nurse	1	5
31	Female	29	Single	Bachelor	Nurse	2	6
32	Female	26	Single	Bachelor	Midwife	2	4
33	Female	23	Single	Bachelor	Midwife	1	1
34	Female	34	Married	Higher degrees	Doctor	3	10

healthcare services to asylum seekers. Especially, nurse and midwife participants reported that they worked more than normal working hours, experienced a lack of healthcare professionals, and could not maintain their professional development during this process. Following these results, different studies also showed that after Syrian asylum seekers came there was an increase in patient circulation, lack of nurses and increase working hours, and a decrease in the time allocated to patients (18,21). In a similar study, physicians working in areas with too many asylum seekers stated that professional development training, career, and promotion opportunities were insufficient and they tended to leave the region in which they worked (22).

The participants described the women's healthcare services they provided to asylum seekers women as unsafe healthcare and treatment. The participants emphasized that patient and employee safety were not provided with the effect of an unsafe healthcare service environment when providing women's healthcare services to asylum seekers women. Also, in terms of patient safety, they stated that experiencing problems while getting information for anamnesis and informed consent due to the insufficiency of translator services caused problems in making the correct diagnosis, applying, and completing effective care treatment.

Participants stated that they had difficulty in getting information for anamnesis and had problems obtaining informed consent for cesarean section and hysterectomy operations. In a study with similar findings, problems were experienced in receiving informed consent from patients who would undergo an operation or

Table 4. Themes, categories, codes and sample quotations identified in interviews with participants

Theme 1	Sub-theme	Codes	Quotations
Theme 1: Challenges	1.1. Unsuitable physical environment and lack of equipment	Delivery room	*"…Delivery room is not sufficient, I wish we had more beds and comfort, but this is what we have, we have to make use of them in the best possible way…" (P1).*
		Blood bank	*"…We don't have a blood bank, I don't know if we get a certain number monthly, but when I say I want blood products to this patient, I get the blood product in one and a half hour. But as I heard, blood products such as thrombocyte suspension are not found even in the centre of Urfa, they come from Antep. Antep is four hours from here (P21).*
		Inpatient units	*"…The patients wait in the delivery room for 12 hours, they can't get in the service because all our beds are full. Right now there are 40 beds in the service, 20 beds in the opposite service, 60 in total. Although we had 80 beds before, this was not enough. (P33).*
		Neonatal intensive care	*"…Since there is no neonatal intensive care unit in our hospital, we have to refer a large number of our patients to another place. I can say that a large number of babies who are referred after delivery are the babies of migrant mothers…" (P21).*
	1.2. Negative working conditions	Working too much	*"… We are assigned to different units, we work too much, we have limited leave, we have shifts every other day and migrant women have a big effect on this workload…" (P4).* *"…We work too much and I feel the need to check what we do all the time …" (P13).*
		Lack of health manpower	*"…This is one of the places with the highest number of births in Turkey, but we have very few nurses, midwives and doctors. I think that increasing the number of healthcare professionals will contribute to providing a more efficient service to migrants and Turkish patients…" (P3).*
		Not being able to maintain professional development	*"…I feel really sorry because I could not develop myself professionally during this process and because I could not add anything to my education life in one and a half year. Because I have limited opportunities and I cannot find time" (P5).*
	1.3. Unsafe health care and treatment practices	Failure to ensure patient safety	*"…We experienced problems with a patient in whom the anamnesis was wrong, the patient had not told us that she had had caesarean section, but thanks God, nothing happened to the patient…" (P31).* *"…They don't want to have caesarean section, why? Because previous caesareans will be a problem, she'll have second caesarean section, too and be able to give birth three or four times …" (P34).* *…There were migrant women who used each other's identities and who seemed to deliver twice in the same year, thanks God, we did not have any problems. Everyone says that they are emergency patients and they generally refer to the emergency service, but when you examine, you see that they can be followed in the outpatient clinic… (P11).*
		Failure to ensure employee safety	*"…We experience verbal arguments, this is mostly due to language problems, delivery is a painful process, we sometimes get beaten, sometimes bitten, everything may happen during delivery…" (P3).* *"…Since we cannot make pre-evaluation, we don't have any information about the patient's previous diseases, we don't know what has happened to them …" (P22).* *"…It creates a risky environment, imagine that we cannot get anamnesis properly, but we have to make an emergency intervention, we don't know if the patient has HIV or hepatitis?..." (P21).*

Table 4 (Continued). Themes, categories, codes and sample quotations identified in interviews with participants

Theme 2	Sub-theme	Codes	Quotations
Theme 2: Reflections	2.1. Providing transcultural health care	Feeling insufficient	*"…Professionally, I feel insufficient, especially not knowing the language, not being able to communicate with the other party is a very big deficit, and communication through translators is not very healthy…" (P25).*
		Feeling unsafe	*"…In fact, it is unsafe because we don't know the culture exactly, some patients tell things which show that they don't trust us …" (P16)*
	2.2. Emotions	Astonishment	*"…I want to tell about a memory. While I was giving breastfeeding training, a migrant woman took out her breast and began to show how she breastfed and then she said that she was breastfeeding for 10 years. I thought she had given birth with short intervals, but it turned out she breastfed each child for 10 years. I can't tell you how surprised I was…" (P1).*
		Anxiety	*"…It causes anxiety because we feel anxious mostly because we don't know about patients' anamnesis and we cannot communicate, we wonder if there's something we are missing. We cannot know their anamnesis completely, for example, we don't know if they had caesarean section or normal birth before, the treatment and the process will be different according to this, therefore, you feel anxious…" (P20).*
		Hopelessness	*"…How can I say, I feel hopeless…" (P23).*
	2.3. Professional experience	Positive Professional experiences	*"…I have seen different patients here, my communication skills have improved and I have developed myself professionally. I have seen different cases, I mean we have improved ourselves, it has more advantages for us…" (P3)*
			"…There is a continuous crisis professionally, we are always in an effort to solve problems. I would feel comfortable even if I encountered very complex cases…" (P27).
			"…It brought great contributions professionally. I don't think that I can have such an experience in any place in Turkey. Not just in terms of gynaecology, but I also had lots of humanly experiences …" (P31).
		Negative Professional experiences	*"…Now I feel less patient. I have asked myself why I have changed, but it is very easy to say when you are on the outside, things are more different when you are on the inside…" (P10).*
			"…I was more patient before I came here. I think I had more tolerance before. Now I feel more rigid. I mean I used to love those differences more in the past, but not now…" (P15).
			"…I feel professionally exhausted. I regret that I did my chosen profession in this way…" (P34).

Table 4 (Continued). Themes, categories, codes and sample quotations identified in interviews with participants

Theme 3	Sub-theme	Codes	Quotations
Theme 3: Needs	3.1. Individualy	Motivation	*"…Here, we need to be motivated to provide an effective health service. But we haven't seen any initiative regarding this so far. The salary paid can never be a source of motivation on its own…" (P24).*
	3.2. Professionaly	Education and training	*"…Transcultural knowledge is not just knowledge to be acquired in professional life. For this, there must be initiatives that start from our education lives. Compulsory courses, compulsory training, continuous assessment…" (P2).*
	3.3. As a team	Multidisciplinary team	*"…The most critical deficiency among our multidisciplinary team is a professional translator. We are aware of this deficiency, Are patients or managers aware of this?..." (P6).*

interventional procedures (23). Lastly, the participants reported that asylum seeking women referred to institutions using the identities of other women, and this situation was a significant threat to patient safety. According to the literature, the lack of identity numbers and identity impersonation to get medication by many patients create suspicion in healthcare professionals (23). The demand for identity information correctness gives healthcare professionals the responsibility of bureaucratic procedures such as checking identities (24). In addition to its adverse impacts on patient safety, it can be said that this situation is reflected in the relationship between the patient and the healthcare professionals, with healthcare professionals losing their confidence in patients.

Regarding employee safety, the participants stated that they were afraid of being exposed to violence and that there was a risk of infectious diseases since they did not know the patients' anamnesis. In the literature, violent behaviors against healthcare

professionals have been closely associated with communication with patients and their relatives and the language barrier (14). Another issue the participants mentioned relating to their safety was that they were at risk since asylum seekers had infectious diseases frequently, but since they could not learn their anamnesis, the diagnosis of these diseases made after the intervention put them at risk. In the literature, the infectious diseases of asylum seekers who experience migration under negative conditions and struggle for their lives under unsuitable conditions are among the situations that scare the host country most (25).

Reflections

While the participants described their experiences in providing healthcare services to individuals from different languages and cultures as unhealthy communication with translators, they also stated that they felt insufficient and unsafe. Similarly, in a study conducted on nurses providing care to asylum seeking women, nurses stated that they felt insufficient (21). In a study that examined the difficulties experienced by healthcare professionals providing women's healthcare services to pregnant women with different languages and cultures, it was concluded that healthcare professionals felt insufficient since they could not communicate with women (26).

While the participants stated that they experienced different emotions when providing service to asylum seeking women, they described these emotions as astonishment, sadness, anxiety, and despair towards different practices and beliefs of women. However, they emphasized that their emotions did not affect their service. In their study, Dias et al. (27) found that healthcare professionals had positive emotions and attitudes toward asylum seekers, while Zhou et al. (28) expressed that the negative emotions nurses developed for asylum seeking patients were due to workload and communication problems. In a study conducted in Iran, nurses stated that they felt hopeless, anxious, and fearful while providing care to patients from different cultures (29).

Lastly, the participants stated that providing healthcare services to asylum seekers contributed positively and negatively. The participants mostly evaluated dealing with patients from a different society as positive in terms of having increased self-confidence, gaining experience in managing crises and patients, and getting rid of biases. In contrast, they evaluated the fatigue and burnout created by negative working conditions, getting impatient with people, and having decreased tolerance as negative. Following these results, it was found in the literature that nurses working in regions where Syrian asylum seekers lived intensely had increased self-confidence, acted more patient and careful, were cautious and courageous, had increased awareness about creativity, and cared about different patients during this process (21). According to the results of studies that focused on the negative impacts of this experience, it was found that nurses and midwives who lived in an area where Syrian asylum seekers lived intensely had higher burnout levels (22,30).

Needs

Participants stated that they needed to effectively provide women's healthcare services to women from different cultures. First, they thought that it was essential to ensure their individual motivation and that this could not be achieved only with financial motivation sources. Many factors such as political, economic, social, cultural, and technological factors affect the motivation of health workers. However, most work motivation theories focus on micro factors (31). These reflections are also seen in practice. However, it is necessary to determine health professionals' working conditions and focus on these conditions and motivation factors specific to individuals.

They expressed their education and training needs that would enrich the transcultural health service provision professionally. Studies continue to make these training programs compulsory in disciplines such as business administration, medicine, and nursing.

The name and content of intercultural courses in medicine and nursing undergraduate programs in Turkey differ, and there is no standardization (32,33). The situation in the world is no different. It was found that intercultural nursing course was compulsory in only 31.6% of nursing programs in Korea (34). It has been reported that medical curricula in Europe are culturally inadequate and that the programs do not evolve in line with the increasing migration (35). It is recommended that the barriers, strengths, weaknesses, and opportunities associated with the different cultures that health professionals serve are determined by SWOT analysis. In other words, what is the process in practice besides the theoretical information? Answering the question is of vital importance.

Finally, they mentioned that the importance of working as a multidisciplinary team in addition to their individual and professional needs and stated that the presence of a professional translator in this team was vital. In the literature, the most difficulties are experienced in the process of giving care to patients from different cultures (36). Aygün et al. (37) stated that physicians providing healthcare services to asylum seekers were unsure whether translators could tell the problems correctly and to what extent they could translate the recommendations and treatment they gave. It is thought that translations not made by professionals are not generally accurate, symptoms are not explained correctly, and essential details are skipped (38). In a different study, it was emphasized that the lack of professional translators, healthcare professionals not having language education, and language barriers when providing health services to asylum seekers were obstacles to patient rights including reproductive rights (39). Patients from different cultures create uncertainty and anxiety for healthcare professionals. Although the presence of an interpreter is considered the gold standard in ensuring intercultural communication, it should not be forgotten that the essential point is health communication. Linguistic and cultural knowledge alone is not sufficient to decide an individual's situation. While it has been suggested that individual efforts cannot overcome language barriers, professional steps should be taken by including the parties receiving and providing service. Also, it is advocated that the presence of effective translators will provide a correct medical interaction, thereby contributing to patient outputs (40,41).

Study Limitations

The data were collected with in-depth interviews, which limited the findings to the expressions of the participants. The majority of the study participants were females (n=30); only four males were recruited for this study. Thus, the experience of the males may not have been adequately explored in this study.

Conclusion

This study narrows the gap in the literature and expands the scope of existing knowledge concerning the healthcare professionals' experience with asylum-seeking women's health care. The results obtained in the study were collected under three themes (1) challenges, (2) reflections, (3) needs. Our results revealed that many factors, especially the language barrier, cultural differences, and ignorance, affected the effectiveness of these services. In addition to the effectiveness of the service provided, the meanings attributed by health professionals to their experiences during this process differ. In conclusion, it was found that the healthcare professionals thought providing healthcare to individuals with different languages and cultures created inadequacy and professional insecurity, they experienced adaptation problems during the whole process, and they had problems with the physical structure and equipment of the hospital they worked in, they worked under negative working conditions, they evaluated the whole process as an unsafe healthcare and treatment service process, they thought the host country was not ready to provide healthcare services to patients with different language and cultures. They stated they should be supported personally, professionally, and as a health team in improving this experience. Our results may help health institutions, managers and policymakers understand healthcare professionals' challenges, emotions, needs and also determine strategies for improving healthcare delivery.

Ethics

Ethics Committee Approval: Approval was obtained from the Istanbul University Social Sciences and Humanities Research Ethics Committee to conduct the study (date: 26.06.2018, number: 66934).

Informed Consent: The participants were provided with necessary explanations about the study (objective, content, and the data obtained would be used only within the context of this study; they had the right to leave the study).

Peer-review: Externally peer-reviewed.

Authorship Contributions

Concept: G.T.Ü., Ü.B., Design: G.T.Ü., Ü.B., Data Collection or Processing: G.T.Ü., Analysis or Interpretation: G.T.Ü., Ü.B., Literature Search: G.T.Ü., Writing: G.T.Ü.

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