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An Ethnographic Study**

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The Care Ethics of Child Health Nurses in Danish Asylum Centers: An Ethnographic Study

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Abstract

Child health nurses play an important role in promoting the health and well-being of children and families seeking asylum. However, little is known about how they establish caring partnerships with families in asylum centers. In this article, we examine the ethical care practices that child health nurses within Danish asylum centers adopt to overcome barriers, related to culture, language and migration history, in delivering care. We conducted ethnographic fieldwork in four Danish Red Cross asylum centers, involving participant observation and individual interviews with 20 families and six child health nurses. A thematic analysis of the material reveals five ethical care practices; compassionate care, humanitarian care, flexible care, collaborative care, and supportive care. We show how the confluence of these types of care enables child health nurses to promote health and well-being of children seeking asylum, and discuss the enabling role of the humanitarian culture that prevails within the asylum centers.

Keywords

asylum-seeking children, child health nurse, parallel humanitarian system, care ethics, family-centered care, cultural humility, Denmark

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Introduction

Nurses have been noted as particularly influential in facilitating healthy transitions for migrant families into their new society (Samarasinghe, 2011). Much has been written about how nurse health visitors can promote the health of adult refugees who have obtained permanent or temporary residency (Burchill, 2011; Burchill & Pevalin, 2012, 2014; Drennan & Joseph, 2005; Pacquiao, 2008). However, little has been done to explore how child health nurses working within an asylum system, support and provide nursing care for children and families who are in the process of seeking asylum. Drawing on Tronto's (1993, 2013) ethics of care, we set out to explore "care" as an ethical practice and examine its role in shaping, and being shaped by, how child health nurses in Danish Red Cross (DRC) settings encounter and respond to the challenges, needs and circumstances of families seeking asylum.

In this article, we first provide some background on the relevance and challenges of nursing care for families seeking asylum and refugee populations. We then provide contextual information on the "parallel humanitarian system" in which our study is situated. Next is a description of our methodology and how we use ethics of care as a conceptual framework

to analyze our empirical data. We then illustrate the five ethical care practices through which child health nurses manage to engage in caring relationships with families who seek asylum. We end the article by discussing the opportunities and challenges for child health nurses to demonstrate cultural humility and family-centered care for children and families seeking asylum, as well as how their culture of care is contingent on their parallel humanitarian context.

Relevance of Child Health Nurses to Support Families Seeking Asylum

During the past century, there has been a shared commitment across many countries to make *health visitors* and *public health nurses* available to general families, to provide universal, preventive, health promoting and holistic services

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(Cowley et al., 2015). Whereas some of these trained nurses have the mandate to support individuals and families throughout the life span, others are specialized to support parents, their newborns and children (Duffee et al., 2017). In this article, we use the term *child health nurses* (henceforth CHNs) to refer to nurses in our study, as they are trained to approach the entire family to promote the health and well-being of children. According to Duffee et al. (2017, p. 1), nurses have the capacity to provide families with the necessary strategies to “buffer the effects of poverty and adverse early childhood.” For children and families seeking asylum, this may include attention to biological, social, and psychological determinants of children’s growth, their general well-being and vaccination status (Udlændinge- og Integrationsministeriet, 2019). Research confirms that children seeking asylum often experience dental problems, infections, mental health problems, and nutritional deficiencies (Kadir et al., 2019; Williams et al., 2016), and are often inadequately vaccinated (Nakken et al., 2018). CHNs working in asylum centers are tasked with preventing and addressing poor health outcomes among children, from an early stage.

Challenges of Nursing Care Among Asylum-seekers and Refugees

As a field of study, child health nursing of children and families seeking asylum is in its infancy. Existing studies on the encounters between nurses and refugees present language, cultural differences, and lack of social support as common challenges to nursing care. In a series of studies on home visits to refugee families in London, Burchill and Pevalin (2012, 2014) observed that it was challenging for health visitors to deliver the care that families needed. The health visitors and families had different perceptions of disease and symptoms, and some families were unfamiliar with home-visits and had other expectations to the health system, than what they experienced. The authors further note that differences in language and cultural beliefs put a heavy responsibility on the health-workers who rarely had the capacity, training in “cultural competence” or resources to meet the disparate needs of refugee families (Burchill, 2011; Burchill & Pevalin, 2012, 2014). Because of such challenges, it is common for nurses to feel time-pressured when caring for refugee families (Ogunsiji et al., 2018; Samarasinghe, 2011). Such challenges are not wholly unproblematic as effective communication and respectful relationships with refugees have been found critical to nursing care (McBride et al., 2016). By “respectful relations”, McBride et al. (2016) refer to nurses’ interpersonal skills, which allow them to tailor care, acknowledging the complex patterns of refugee patients’ lives, which require resources, time and cultural sensitivity. Ogunsiji et al. (2018) similarly pointed that it is crucial to work within a structure that encourages and supports nurses who care for refugee families; that acknowledges the need to invest more resources into their work; and

that is willing to make these investments. Because we recognize the complexity of nursing care for refugee families and families seeking asylum, we want to examine how CHNs encounter and respond to the challenges. Rather than focusing on obstacles to child health nursing, we set out to explore enablers and pathways to care of children and their families, with heightened attention paid to the contextual influences of a parallel humanitarian system, such as DRC asylum centers in Denmark.

Families in the Danish Asylum system

Our study is located within a humanitarian setting. In 2019, there were 14 asylum centers in Denmark, of which six were run by the DRC, which has been running asylum centers through a contract with the Danish Immigration Authorities since 1984 (Danish Red Cross, 2020). Seeking asylum in Denmark involves different phases relevant to our study. *Phase One* is when families arrive in the DRC-run reception center (Udlændingestyrelsen, 2019), where they are registered by the police, interviewed by the immigration authorities, and offered a medical check in the DRC health clinic. During this period after, potentially, a highly stressful, exhausting migration flight, families experience high hopes and great relief, related to what some scholars refer to as “the honeymoon phase” (Lennartson et al., 2007). In *Phase Two*, families live in a regular asylum center while awaiting a decision on their application. If the immigration authorities initially decline the application, an appeal is automatically forwarded to the Refugee Appeals Board. Families awaiting a final decision from the board are still considered part of the second phase. This period may last for years, and this “waiting phase” has been associated with pervasive uncertainty for many families (Vitus, 2011). It is common for families to be moved between different centers, often many times. Healthcare for families in the Danish asylum system is offered parallel to the formal healthcare system, and within the asylum centers’ own health clinics. Adult asylum-seekers are entitled to necessary, urgent and pain-relieving healthcare, whereas children formally have the same entitlements as children with Danish residency (Hjern & Østergaard, 2016). This includes the child health program, offered primarily by CHNs.

Child Health Nursing in a “Parallel Humanitarian System”

The CHNs we follow in this study are humanitarian workers, who together with their colleagues (general practitioners, nurses, teachers, social workers, and network staff) are employed by DRC to ensure asylum-seekers have “a safe, meaningful and dignified everyday life” irrespective of their status as asylum-seekers. This entails among other things services parallel to those of Danish residents, such as day-care and schooling for children (Danish Red Cross, 2020).

During our fieldwork, we noted that all DRC employees wore red jackets with the DRC logo, to clarify their humanitarian role for families and to disassociate themselves from the police and immigration authorities who were also active in the DRC asylum centers. On a typical day, a CHN would have consultations with two to five families, depending on the number of children within a family. The rate of influx of families into the asylum center was far from stable. Over 1 week, fewer than ten children could arrive with their families, whereas more than ten might arrive over a single weekend. In the reception center, the CHNs' main tasks were to collaborate with a doctor in offering voluntary initial medical checks of the newly arrived children; obtaining an overview of the children's health and well-being and their parents' resources; and informing and mobilizing other potential services within the reception and regular asylum centers. In these asylum centers, CHNs were responsible for following up on any matters noted from their CHN counterparts at the initial reception center, as well as offering voluntary consultations with pregnant women, children and their parents on a regular basis. The CHNs in our study thus work in what we call a *parallel humanitarian system* in which tasks and services related to asylum-seekers are outsourced by immigration authorities to humanitarian agencies such as the Red Cross which fosters a particular humanitarian care culture. Although this is a rare model, it is not unique to Denmark and reflects a *modus operandi* in other countries (Hjern & Østergaard, 2016). We thus hope to provide insights that are transferrable to contexts with similar parallel systems.

Method

We employed an ethnographic study design to explore CHNs' ethical care practices, their embeddedness within a particular setting, and how they are experienced by families seeking asylum. Ethnographic fieldwork enables in-depth insights of everyday lives and experiences, and explicit and subtle practices through systematic observation of, and participation in, conversations and practices (Madden, 2017). Between November 2017 and March 2018, the first author, AB, performed participant observation and interviews in four asylum centers operated by the DRC. The fieldwork forms a sub-study of a larger project on health and integration among refugee youth across Nordic countries *Coming of Age in Exile (CAGE)*, funded by The Nordic Research Council (NordForsk). This sub-study set out to explore health reception practices in the asylum system, but as we explain later, the analysis presented in this article focuses on one specific health reception initiative performed by CHNs.

The study was approved by the Danish Data Protection Agency. Qualitative research is not subject to ethics committee approval in Denmark. All participants in the study explicitly gave their verbal informed consent based on an information letter. The letter included our contact information, described our independence and that of the research

project in relation to immigration authorities and the DRC. It further described the broader aim of the study, how the interviews would be used, and the participants' possibility of withdrawing at any time. Before each observation and interview with families, the information letter was read aloud by AB, and the interpreter translated it verbally. Families then received a written copy in Danish, English or Arabic. To maintain confidentiality, we have anonymized all identifiable information of all participants.

Negotiating Access, and Researcher Positioning

Researchers who undertake fieldwork within an asylum center context emphasize the challenges of negotiating a position that facilitates cooperation and generates rich insight, especially into families' everyday lives (Shapiro, 2017). This was echoed when AB negotiated access and position in the field. As there is only one reception center in Denmark, it is a popular setting for researchers with an interest in newly arrived asylum-seekers. The manager of the health clinic initially said that they therefore received far more research inquiries than they were capable of accepting, and she also perceived participation in research as a threat to the safety of newly arrived asylum-seekers. AB had been trained in migration and health and had a long-standing research interest aimed at improving access and equity in health for the benefit of vulnerable and migrant groups. This background enabled her to gain initial access to perform observations. Entering the field however first involved a negotiation with the humanitarian CHNs, who advised against contacting families in the reception center, as they were preoccupied by registration and interviews with the police and immigration authorities. An invitation for a research interview could therefore lead to confusion about the interview purpose and our role as researchers. The CHNs instead advised conducting the study in regular asylum centers, with a reminder to be cautious as some families could be burdened by a wait of many years for a decision on their asylum application.

Negotiating a position that enabled insight was however more straightforward, when AB first gained access to families. She embodied several characteristics familiar to the families: pregnant in the third trimester; belonged to an ethnic and religious minority in Denmark; and spoke limited Arabic, and therefore able to use several Arabic (or Islamic) phrasings when encountering families (for instance, the greeting "Salam u Alaikum," and "Insha'Allah" meaning if God will). We noted this fostered trust and helped build rapport with the families. For instance, both adults and children recognized, smiled and waved at AB days after having met her during their consultations with the CHNs in the reception center. In regular asylum centers, this position fostered a fruitful relation with families during interviews, despite their burdens of seeking asylum and living in asylum centers being both evident and articulated. These developing relationships with the families further supported a disassociation from the

“authority figures”—bodies of whom the families could be rather wary: the police, immigration authorities, and even health professionals and the DRC. Families decided on the location for interviews, either in their rooms or at the health clinic. During interviews that took place in families’ rooms AB was often treated as a guest who was served tea and cookies. Families willingly shared their experiences, aided by the many shared reference points between her and the families. For instance, in conversations about mother/parenthood, and on belonging to an ethnic or religious minority in Denmark, she was able to adopt an emic perspective, which fostered fruitful interactions and more in-depth insights into families’ experiences. Families usually expressed gratitude for being listened to, and sometimes expressed hopes for improvements of their asylum conditions, despite they were explained that influencing policies was only a long aspiration of the research. Other scholars have similarly highlighted how asylum-seekers may perceive researchers as enabling a testimony of their life stories to reach the world (Zion et al., 2009). We recognize the positioning of AB, and how her personal background, training in public health, and interest in promoting the rights and accessibilities of underserved groups as enabling empirical data of quality, as she became “close, but not too close” (Madden, 2017, p. 79); both in the interactions with families during data collection, and how she made sense of and analyzed the data.

Recruitment of Study Participants

The participants in our study (20 families and six CHNs in total) were recruited through snowball sampling. The administrator of the health clinic in the reception center acted as our “gatekeeper” to the CHNs, helping us make contact with them. We included all the CHNs who accepted an invitation to participate (six out of seven in total). The CHNs were familiar with the families from consultations. They assisted in the recruitment of families, either by direct invitation during a consultation with a family, or by suggesting specific families who gave CHNs permission to share their contact details with AB, whom then invited them to participate in the study.

Participant observations were performed by following three CHNs in the reception center, who also participated in individual interviews. Three other CHNs in regular asylum centers were also interviewed, and helped us make contact with families. Nine families in the reception center participated in the observations, whereas 11 families in regular asylum centers were interviewed (see Table 1). The families in the reception center had only been in Denmark for a few days, whereas those in regular asylum centers were awaiting a final decision of their asylum application from the Refugee Appeals Board. The six CHNs participating in the study were all Danish white women. They had all previously been working in a Danish municipality, where they performed child health nursing practices according to national guidelines on

programs for all children in Denmark. Table 1 provides an overview of the participants and empirical data used in the study.

Data Generation

We developed an *observation guide* to direct the observations of the consultations, focusing attention on the physical localities and objects, the actors, actions and communication taking place, and the overall temporal and contextual setting of our observations. The observations took place within the clinics held by the CHNs, before and during the initial medical check with children and their families in the reception center, and each lasted about 1 hour. Notes were taken throughout the observations, which were expanded into field notes later on the same day. Informal conversations were held with DRC staff at the center during lunch and between consultations in the clinic, using these conversations to add detail to the field notes. We further developed a semi-structured *topic guide* for the interviews, partly informed by initial insights from the observations. This included topics and questions to direct the conversation with the informant, and was designed specifically for CHNs and for families. Topic guides were designed to generate insight into CHNs’ accounts, perspectives, motivations and experiences in their consultations with families, and into how the families experienced the care provided for their children. Of the interviews conducted with families, two were in English and one in Danish. The remaining interviews were conducted in Arabic and Sorani (Central Kurdish) and mediated by professional interpreters fluent in the respective language of the informants. Interpreters were both male and female and were identified from an approved service by the Danish Refugee Council. That AB was familiar with some Arabic words, meant that she understood some of the meaning articulated by families, yet not enough to carry out the interviews without interpreters. Her limited Arabic proficiency also enabled to audit the quality of the ongoing interpretation of the interviews as well as the quality of the interpretation service. While we were unable to audit the quality of interviews conducted with the Sorani-speaking interpreter, the interpretation service was overall assessed as of high quality. The interviews with CHNs were in Danish, and needed no interpreter as all members in the research team are native Danish speakers. All interviews lasted about 1 hour, were audio-recorded and transcribed verbatim to the language of the interviews (Danish to Danish, English to English). Excerpts used in this article were then translated into English.

Data Analysis: Understanding Child Health Nursing as an Ethical Care Practice

We imported field notes and transcriptions into NVivo 12, and performed an iterative and thematic analysis. We first developed a list of codes from the more exploratory analysis.

We developed these codes inductively, with little consideration of theory. We developed 128 codes, which were applied to the entire data corpus. During coding it became clear that much of our data spoke to the care practices of CHNs. We consulted theories and concepts that could help unpack the different types of practices carried out by CHNs to support children and their families, and found that Tronto's (1993, 2013) feminist theorization of ethics of care would be useful for this purpose. The framework suggests that individuals' approach to care is socially contingent, both on their particular social relationships and the power structures in which they are embedded. We especially draw inspiration from her delineation of five phases of ethical care: "caring about," "caring for," "care-giving," "care-receiving" (Tronto, 1993), and "caring-with" (Tronto, 2013). We use this to unpack care practices within the specific relation between CHNs and families seeking asylum. To heighten our attention to the role of context, and the particular care cultures emerging within this humanitarian setting in Denmark, we also found inspiration on the work of Shove et al. (2012). They argue that routinized behaviors (such as CHNs' care) are formed by the configuration and confluence of materials, meanings and competencies evident within a cultural setting. We drew on these theoretical frameworks to select the 51 codes that provide insight to the CHN's care practices. With help from Attride-Stirling's (2001) thematic network analysis approach, we collated the 51 codes into 13 basic themes. These were in turn clustered into five organizing themes, each relating to one of Tronto's phases of ethics of care. For instance, *caring about* could refer to when CHNs are attentive and recognize that children and families in the asylum system have unmet care-needs. *Caring for* could be when CHNs take responsibility for meeting families' needs, as well as for fulfilling CHNs' own assigned obligations. *Care giving* may refer to CHNs' competencies and capacities to provide care, whereas *care receiving* may refer to how the families respond to and evaluate CHNs' care. Finally, *caring with* could help us unravel how care is never performed in a vacuum, but is, by nature, a relational and interdependent endeavor, such as a partnership between CHNs and families based on reciprocity and collaboration. The five organizing themes were finally connected to one global theme (see Table 2). The five themes constitute the sub-headings that structure the presentation of our findings in the following section.

Findings

In the following, we present the *five interrelated ethical care practices* that we found CHNs to adopt in response to the range of challenges, needs and circumstances that influence the capacity of children and families in asylum centers to receive care: (1) Compassionate care; (2) Humanitarian care; (3) Flexible care; (4) Collaborative care; and (5) Supportive care (see Table 2). In this section we will illustrate how these five practices are relational and overlap, and examine how

they are contingent on the abilities of CHNs to forge relationships with families seeking asylum.

Compassionate Care

The CHNs' compassionate care involved their attentiveness to the families' complex needs for care. This was driven by their empathy for, personal interest in, and motivation to safeguard families and children who had migrated from their homes involuntarily, and were seeking asylum in a new country. The CHNs often described how their work was "meaningful" because they experienced their support being needed among families. Nearly all CHNs described their decision to work in the DRC as driven by an interest in "vulnerable groups" and "other cultures." We noted how this fostered motivation and compassion in their work. For instance, CHN 6 said that she "should have started to work here 10 years ago" and was "planning to grow old in this field." One specific aspect of their compassion was how their engagement in supporting children occupied their minds, including at the end of the working day:

I always have this feeling about whether the children I meet are doing well or badly. It's my obligation to ensure that children here have a good everyday life. I don't sleep well if I'm aware that something is wrong or if a family isn't doing well. (CHN 2, in interview)

Apart from demonstrating immense compassion for the children's well-being, this account indicates that the care practices CHNs perform may be based on a "feeling"—an intuitive skill which is intangible to describe or learn (see also *flexible care*). Similarly to how CHN 2 was affected by concerns about specific children, we identified that many CHNs would go beyond their formal nursing responsibilities because of such worries:

When I was employed at this reception center, I had to get used to the fact that I couldn't follow up on the worries I had for some children but instead just hope that their new CHN would follow up on them. Sometimes, I actually go back and look in the records, and check how the children are doing—even when I'm not responsible for their child health nursing anymore, but [I feel I] just have to follow-up on one specific issue. (CHN 1, in interview)

This quote illustrates the CHNs' engagement and empathy in *caring about* (c.f. Tronto, 1993) children and their families. It explains CHNs' motivation in taking extensive responsibility for ensuring children's ongoing well-being. In another example, several CHNs would send text messages to the families, with reminders about their consultations in the clinic. In their efforts to establish and maintain relations with the families, the CHNs also showed their compassion. They strived to be trusted by parents through "good personal chemistry." Several CHNs emphasized that parents were

Table 2. Overview of Thematic Network Analysis.

Global theme	Organizing theme and relation to conceptual framework	Basic theme
Care practices of child health nurses (CHNs) working with children and families in Danish Red Cross (DRC) asylum centers	Compassionate care <i>Caring about</i> : personal motivation, empathy and CHNs' attentiveness to families	CHNs have a personal interest in families with other cultures CHNs believe their work is meaningful CHNs have empathy for the families CHNs listen to parents' stories as a strategy CHNs are obliged to do humanitarian work as DRC employees CHNs draw on their professional knowledge and tools
	Responsible care <i>Caring for</i> : responsibilities and obligations of CHNs in DRC asylum centers	The setting(s) may be chaotic Informal and experience-based knowledge is crucial CHNs do a large amount of "tinkering"
	Flexible care <i>Caregiving</i> : capacities and competencies CHNs use during their concrete practices	CHNs collaborate with parents to care for children CHNs collaborate with other professionals CHNs support parents in taking care of own children
	Collaborative care <i>Caring with</i> : CHNs' interdependency on other actors Supportive care <i>Care-receiving</i> : parents' and families' responses and evaluations of the care they received from CHNs	Parents receive new information, advice and tools to care for asylum-seeking parents' children

usually positive toward the CHNs, because "these parents had left their homes [i.e. their home countries] to obtain a better life for their children." Moreover, the CHNs often patiently listened to parents' life stories and their concerns about being asylum-seekers. Listening was described as both a strategy to establish a trustful relationship with parents, and also a tool to better understand families' needs for care. Trust could further be strengthened when CHNs listened to, and advised on, other aspects of the adult-life of parents, ranging from family planning and sexual topics to loneliness and losing weight. This was exemplified by the mother in Family 11: "Sitting in front of this woman, talking and she listens [to me]. She gives you time and space. You feel welcome." Thus the CHNs' compassion—formed by their shared interests with parents and their empathy in listening—facilitated a trustful and enabling partnership with families. It allowed the CHNs to recognize, and attend to, needs related to the health and well-being of children and families.

Humanitarian Care

The CHNs' care culture was enabled by their intersecting roles as nurses with training in child health and well-being, and as humanitarian DRC employees. This was not only rooted in a moral ideal regarding their professional and humanitarian roles as CHNs within the DRC, but also visible in their actual care practices, where they recognized their own responsibilities and obligations in meeting the care needs, and *caring for* (c.f. Tronto, 1993) children and their families.

In practice, their "humanitarian care" manifested in different ways. When meeting families for the first time, CHNs spent time informing them about their principles of neutrality, emphasizing their separation from the (generally unpopular) immigration authorities and police, who the families had already met for registration and interview. Several CHNs described how they were responsible for ensuring families had "a safe beginning" in the Danish asylum system. Being the first neutral actors (i.e., unlike the non-neutral authorities) to meet the families, and with the interests they shared with parents about the children the CHNs' initial work in the reception center was described as providing "a good entry-point" to support the families from the very beginning of their arrival in Denmark. CHN 1 said that, as DRC employees, they were obliged to support the families "right now and right here" and "as if they are staying forever." This indicates that the uncertainty during families' asylum-seeking period promoted the CHNs' humanitarian care culture to come to the fore. For instance, although families lived in uncertainty and ignorance as to whether their asylum application would be accepted, CHNs approached the families as if they had a future in Denmark. They provided advice on nutrition, sleep, schooling and play according to Danish standards and guidelines. Apart from it being an opportunity to hand out material objects related to children (toys, vitamins, toothbrushes, clothes, and toiletries), a safe beginning was turned into a matter of introducing the parents to the practices of child-care. CHN 1 further said that her care was "the 'Maggi-cube' of child health nursing, you know the one you put into the sauce, and then it becomes good." With this, she referred to

the fact that the CHNs could potentially discuss every aspect of healthcare with each family, ranging from newborns, children's nutrition, growth and sleep, aggressive toddlers, traumatic or other mental reactions, the importance of socialization, playing, kindergarten and school, and so on. This meant that there was great potential early on among families to receive and implement information from the CHNs. In this way, communication of important aspects of child health became integral to the CHNs' work:

My most important and dignified task is to inform and communicate knowledge on health, and the specific aspects where a parent can actually do something to create good living conditions for one's child. It's important because it creates well-being among the children. (CHN 5, in interview)

This CHN emphasized the importance of communicating knowledge on children's health to parents. By mentioning what parents "can actually" influence, she implied that there are many structural aspects which asylum-seekers cannot influence but which have a huge impact on their well-being (e.g., where to live, length of time waiting for decision of asylum application, etc.). In the CHN's account, parents could implement her information and thereby create some well-being among their children, who were at risk of adversity given their circumstances in the asylum center. Thus, the CHNs perceived themselves as crucial actors in supporting parents in safeguarding their children's health and well-being. CHN 4 also described how, in a further description of their key role, CHNs were further responsible for "maintaining the good connection between parents and their children in this crisis situation, where all the chaos around them can disturb it and when everything else is not going well." The CHNs' sense of humanitarian care was entailed in their personal and professional responsibilities: As the mother in Family 11 said, to be both "a good human and a good professional" at a specific point in time during the families' migration.

Flexible Care

The actual work of *giving care* (cf. Tronto, 1993) was enabled by the CHNs' competencies and skills of being flexible and constantly tailoring their care to individual children and families. The CHNs both recognized and acknowledged that their capacities to care for children and their families were limited by pervasive uncertainty caused by the asylum system. This uncertainty not only dominated families, but was also a condition of the CHNs' intersecting roles as CHNs and humanitarian workers, which complicated their work. CHN 6 said that "this is truly not the first workplace you choose as a new CHN," implying that it required a certain persona to work in their field. Namely, one obliged to carry out humanitarian work, yet in the face of limiting legislative and other structural barriers. Despite their compassion and engagement, and

their willingness to go beyond their actual duties, these structural conditions inevitably limited the care they were able to provide to the families. For instance, CHN 1 explained that "the most challenging [thing] about this work is all the uncertainty. Will families get residency? Or will they be sent back to their country? What happens to them during and after this?"

The families seeking asylum were living in adverse conditions, and both CHNs and families often told stories about distress caused by families' waiting for an asylum decision. Spirits were low among children and it was difficult for them to form friendships because of the sudden relocations between asylum centers. The families' first priority, and most articulated need, was to obtain asylum. CHNs often felt that they had to let families down, for example when being approached by families who hoped the CHNs could help their asylum case to be approved. This challenged the trustful relationship with parents which CHNs strived to maintain. Furthermore, the inevitable physical or telephone presence of an interpreter, who mediated all communication between CHNs and non-English non-Danish speaking families, challenged the extent of how engaging and flexible the CHNs could be in their care. Moreover, the families received weekly allowances from the authorities, and sometimes it was insufficient to cover expenses for the type of food that CHNs advised them to cook for their children. Nonetheless, we found that the CHNs articulated these complexities as inevitable working conditions rather than specific barriers, and they drew on past experiences and their intuitions to work under these conditions in their care practices. By drawing on "feelings" and informal knowledge the CHNs often "tinkered," being both adaptable and tenacious, and adjusted their care to every unique situation (Mol, 2008). This was noted in a participant observation that began with a fire drill lasting 40 minutes, resulting in the CHN falling behind her patient schedule for the day:

After getting back to the clinic, CHN 2 asks the mother about her son's vaccinations, but she doesn't know. After having looked in the papers the mother brought, CHN 2 decides that the boy should receive the full Danish vaccination program. "Just in case. Now, let's check your sight," she says while looking at the boy. She explains the procedure: She is going to point at different "E"s on the sight chart, and he can either tell the direction of the "E", or show it with his hands. An interpreter mediates their conversation by telephone. The boy smiles and nods. He seems curious and content. The CHN shows him where to sit, and then she starts pointing. He doesn't reply, even though the translator tries to explain. She gives him a "waiting" look. He giggles, seems confused and has not understood the task at all. It's suddenly noisy with the CHN explaining what he has to do again, his mother also getting involved, the boy asking questions in Arabic and the interpreter trying to mediate all of this. After a couple of chaotic noisy minutes, and the boy pointing in numerous directions with his fingers, the CHN stops: "You know what, let's try something else." She wipes sweat off her forehead,

and looks around the clinic. She takes out another chart: "It's not as good as the other, but I'm sure it's the best we can do." She smiles, and switches the chart to one that has different figures on it. She turns to AB, shrugs her shoulders and sighs: "This is for much younger children, but we'll manage." (Field note from observation of consultation 1)

Instead of using the sight chart prescribed to the boy's age, the CHN navigated within the "chaos" and adjusted her strategy to accomplish her task. Another strategy shown here, also used among other CHNs, related to the assessment and planning of vaccinations: In case of any doubt as to the children's vaccination history, they would be offered the full program, despite the possibility of double-vaccinating. These strategies were all based on the CHNs' past experiences, and practiced based on an objective of "doing as well as possible" within specific care consultations. In some situations this flexibility went very far, as observed in a consultation where an unhappy mother explained how her daughter only drank milk if she mixed it with Nescafé. Surprisingly to AB, who expected a more draconian response, CHN 1, with an interest in ensuring the child's need for calcium was met, replied, "That's fine! You can also try a spoon of cocoa." She here adjusted her care by suggesting cocoa as an alternative to the caffeinated drink to solve the mother's problem of making the milk tasty to her daughter. Rather than perceiving this act as conflicting with the CHN's health professional conduct, we emphasize it as one example of how CHNs provide tailored care. By drawing on professional, humanitarian and compassionate assessments of every family's individual situation, the CHNs catered for their specific needs.

Collaborative Care

To support the children's health and well-being, the CHNs were also dependent on "collaborative care" practices. Their *caring with* (c.f. Tronto, 2013) unfolded in partnerships with parents, which occasionally also involved inviting other professionals into the collaboration. A good relationship between the parents and CHNs was important, yet a dilemma to maintain, as the parents were often pre-occupied with concerns about their asylum process, undermining their engagement with the CHNs. As mentioned previously, the shared interest of CHNs and parents in the families' children enabled parents' trust and collaboration. Most parents were attentive to the CHNs' recommendations because of CHNs' professional advice-giving legitimacy. Collaborations unfolded variously and could often be initiated by parents. For example, the young mother in Family 8 used the CHN to initiate a difficult, but necessary, conversation with her 14-year-old son about puberty, as she thought it was "embarrassing to talk with him about his genitals and those things." This mother had met with CHN 6 alone and explained her challenges whereupon they agreed that the CHN would take on the task. In this way, the CHN and mother cared *with* each other to

inform the adolescent about his physical transformation. Both families and CHNs described several cases where children's mental reactions to previous traumatic experiences unfolded in physical reactions such as abnormal bed-wetting or unhealthy eating habits. Here the CHNs would care *with* the parents to overcome these reactions, and when they found their own expertise to be inadequate, other professionals would be invited into these partnerships, such as psychologists or social workers also employed by the DRC. This is exemplified by a CHN who observed how the mental health of a mother and father were having an impact on their four children:

The children were sad and never stimulated. The parents didn't even know, or rather had forgotten, how to play with their children. We provided counseling in their home, with staff from our kindergarten and our psychologist. We basically taught them how to play. It worked. It sounds crazy, but of course, it did. These children got to play and became so much happier. (CHN 2, in interview)

In collaboration with their colleagues in DRC, the CHNs here became able to care *with* the parents in a way where they taught them, concretely, how to stimulate the children to promote their well-being. Collaboration, either between parents and CHNs or involving other professionals, always necessitated a trustful relationship between the CHNs and parents, and these partnerships often encouraged parents to care for their own children.

Supportive Care

The CHNs supported families in ways that were appreciated and responded to by the families (c.f. Tronto's (1993) *care receiving*). Many families had positive experiences to share about their consultations with CHNs. They often described how the CHNs had provided them with practical, eye-opening and useful advice, which they could use and apply in their everyday lives. As for the mother in Family 9, the families were receptive to such advice because they experienced how CHNs provided it in a respectful and compassionate way:

I take from the CHN what I think is suitable for me, my situation and for my life. She told me that she wanted to talk about my overweight as a friend to friend. "You are still young, you should be better at playing with your kids," and such like. She advised me on what to do and she said I should try and think about it, and how I live my life is dependent on myself. She has an open mind and I do too. (Mother in Family 9, in interview)

By receiving this specific information, this mother felt supported to improve her own habits and also the care of her children. She emphasized that it was especially the CHN's "open mind," where she respected the mother's autonomy that made her follow the advice. For many families, it was

new to have such professional support, as the mother in Family 7 for instance said: “At home, there’s no CHN. We learn how to become a mother from mother to daughter, from friends and neighbors. But here, it’s really *magical* to have a CHN who advises you and tells you.” This mother illustrated how she became empowered to take on her new role as a mother after meeting a CHN in the asylum center. Thus, the fact that health promotion services had been rarely offered in the countries from which the families seeking asylum originated, created a strong feeling of empowerment among many families who had come to Denmark. Occasionally, however, we also noted this unfamiliarity to foster a criticism toward the role of CHNs, as the mother in Family 2 described: “It’s fine that the CHN monitors my child’s growth and vaccinations, but I raised four children already, and I know how to do things.” As part of the supportive care, one CHN also explained how parents did not only need to know how to care for their children. They also needed to be acknowledged and “uplifted” for what they actually did themselves, and much more than parents with Danish residency:

If I have two parents who sit with the baby lying in their laps, and rock the baby to sleep with their legs—and are fine with having to do this every night—I acknowledge them for meeting their baby’s need for sleep, despite them doing it in a way that is untraditional in Denmark. If they however express a need to change this habit themselves, then I’m available to support and guide them. (CHN 5, in interview)

Here, CHN 5 emphasized the importance of respecting families’ own traditions, as long as they did not counteract the well-being of the child. Thus, the CHNs’ supportive care also entailed encouraging parents to be confident and autonomous in taking care of their own children.

Discussion

In this article, we set out to unravel the ethical care practices of CHNs in Danish asylum centers operated by the DRC. We found that CHNs steered, and were steered by, a profound culture of care, which manifested itself through compassionate, humanitarian, flexible, collaborative, and supportive care practices. In the following, we seek to argue how these interrelated care practices demonstrate *cultural humility* and form constituent parts of *family-centered care* for children and families seeking asylum. We then discuss how CHNs’ culture of care is contingent on their parallel humanitarian context.

Ethical Care Practices, Family-centered Care, and Cultural Humility

Our findings suggest that CHNs went to great lengths to involve parents in asylum centers, and tinker with services to attend to the families’ specific situations. Driven by compassion, they

listened to families’ stories, both to gain their trust and to understand, identify and attend to their different needs. Listening enabled CHNs to tailor their care, as they obtained insights into the capacities of individual children and parents. This “caring about” is central to family-centered care (FCC). FCC is a partnership approach to healthcare, in which professionals tailor services to match the specific capacities and needs of families, through shared decision-making (Kuo et al., 2012). In a concept analysis comparing “family-centered” and “culture-centered” care approaches, Lor et al. (2016) observed that both approaches promote respectful and holistic care, collaboration and effective communication with families, inter-professional coordination and collaboration, and professional self-awareness and cultural skills. Through the five ethical care practices we identified, the CHNs in our study consistently demonstrated FCC and maintained some form of “cultural humility.” Foronda et al. (2016) emphasize cultural humility as a life-long learning process involving professionals’ openness, self-awareness and enthusiastic interactions with care-receivers who have diverse backgrounds. In our study, this referred to several aspects within the CHNs’ care: How they willingly interacted with families seeking asylum; explicitly articulated critical thoughts about their own ideals and approaches; accounted for the importance of such awareness for respectful care to the families; and how they experienced their training and role as humanitarian CHNs through their daily work.

We especially found that listening, as a particular strategy to tailor care, was rooted in CHNs’ openness and empathy. This was part of their compassionate and humanitarian care, where they both recognized families’ distress and needs for care, and correspondingly recognized their own obligations and responsibilities to relieve families’ distress by attempting to meet their needs. By being compassionate and humanitarian, and by listening respectfully and curiously, CHNs were able to establish collaboration and relationships focusing on the “family as unit of care” (Kuo et al., 2012; Lor et al., 2016). This corresponds to the arguments in a discussion article on nursing care of refugees and asylum-seekers, where Pacquiao (2008) argues that compassion indeed is key, because it stems from an empathetic understanding of the suffering or distress of individuals, and a consequent commitment to act to relieve such suffering. The CHNs in our study further recognized and respected heterogeneity among families by attending to their own concerns, traditions and personal ideals. They invited families to engage and collaborate, and adjusted their care, and their own desired outcome of this care, according to how a specific consultation unfolded. This is consistent with Kuo et al. (2012) description of how FCC also involves respecting and honoring differences and care preferences, where families and professionals collaborate and negotiate desired outcomes of a given consultation.

The CHNs thus responded to families with knowledge, skills and capacities, related to their formal education, humanitarian training *and* their (inter)personal motivations

and competencies, in ways that made families feel respected and supported. Such experiences among families as care-receivers are indeed the desired consequences of FCC (Coyne et al., 2018; Kuo et al., 2012; Lor et al., 2016). Based on our findings and their interrelatedness with crucial concepts highlighted in literature on FCC and cultural humility, we argue that the CHNs, through their ethical care practices, perform FCC. Furthermore, we suggest that these ethical care practices may set the framework for FCC of families seeking asylum.

The Humanitarian Context: Opportunities and Ongoing Struggles

The CHNs in our study experienced challenges in their encounters with families seeking asylum, similar to studies discussed in our introduction. However, they navigated these challenges in creative ways, partly enabled by their humanitarian context. Duncan (2015) has noted that such creativity is a critical but rare characteristic among health professionals who work with refugees. A key finding of our study is that this creativity was highly contingent on the opportunities arising from working within a humanitarian context.

In much of the literature discussed in the introduction, nurses worked with all sorts of families or may have been assigned to work with refugees on a temporary basis (McBride et al., 2016). This stands in contrast to the CHNs participating in our study who have actively chosen to specialize and work with asylum-seekers. The CHNs in our study may therefore have greater motivation and capacity to work with vulnerable families who experience various challenges. Moreover, the CHNs are making careers within DRC asylum centers, offering health services within a humanitarian system that run parallel to the national healthcare system. The DRC operates the asylum centers through annual contracts with the Danish immigration authorities. The asylum centers therefore do not operate within a vacuum, but are highly dependent on the political landscape. We observed this to negatively affect the scope of CHNs' ethical care practices. Processing of the families' asylum cases may be protracted, shutdowns of asylum centers may lead to families being continuously moved around, and accommodation of families is arranged by the authorities. We observed powerlessness and distress among several of the participating families, as a consequence of this pervasive uncertainty. We observed such precarity to challenge the work of CHNs, who struggled to build up productive care relations with families losing hope or trust in the system. This echoes the findings of Vitus (2011) who has observed how the lengthy processing of asylum cases, frequent relocations between asylum centers, and family separations lead to family breakdowns. This also made it hard for professionals to integrate and support the families. In our study, families' distress could work against the scope of CHNs' care. One aspect was the

temporariness of families' residence in asylum centers. This meant that CHNs' care processes with specific families could be suddenly interrupted, either because the family was moving to another center, was declined asylum and repatriated, or because they disappeared. Whereas the mobility of the families seeking asylum challenged the CHNs' continuity of care, the humanitarian context encouraged them to treat families in their care as if they were staying forever. This approach enabled the CHNs to develop care relations characterized by deep and long-term engagement, above and beyond basic health needs. This finding stands in contrast to findings by Drennan and Joseph (2005) which found that health visitors in the UK, because of the mobility of refugees, could not establish caring relationships, but merely respond to basic physiological health needs of refugee families. Robertshaw et al. (2017) have similarly highlighted how the lack of permanent residency obstructs the delivery of continuous and long-term care. The CHNs in our study instead managed to form caring relations, especially with families who had been in the asylum system for many years. The families' access to child health nursing within this parallel humanitarian context may thus be higher than to healthcare in general communities, as the clinics are often located within, or near, the asylum centers. Relatedly, we found the humanitarian system made available a health-enabling environment, beyond what the national legislative documents call for. In a recent review of national policies, we noted an absence of policy documents making provisions for health promoting care in the shape of "family-support", "dialogue", "participation" and "play" (Barghadouch et al., 2019). Irrespective of the legislative context, the CHNs in our study actively promoted these elements through their ethical care practices.

The observation of what a parallel healthcare and humanitarian asylum system may offer raises interesting questions regarding how differences in healthcare and asylum systems shape how families eventually navigate the general healthcare system. In Sweden, where healthcare for asylum-seekers is organized within the national healthcare services, Kalengayi et al. (2015) found that many asylum-seekers did not attend medical examinations because of lack of information. However, we often observed that CHNs went to families' rooms to inform them about consultations, and even that some families would immediately follow the CHNs to the clinic. Future comparative research could explore how different organizational systems of healthcare for asylum-seekers influence both professional practices and families' experiences. As our study only provides a snapshot into a particular context and period of the studied children and their families, further research is also needed to obtain insight into families' experiences both of CHNs and of their access to the national healthcare system after gaining permission to reside, and moving to a municipality. Furthermore, future research ought to involve and consider the perspectives of children, as they are the receivers of the care explored in this article.

Study Limitations

Our findings need to be considered in the context of some limitations. First, the families participating in interviews had all experienced an initial rejection of their asylum case, and were awaiting decision of their appeal at the Refugee Appeals Board, which may have led to distress and low spirits. This could be reflected in negative claims against the CHNs. However, as our findings indicate, the families' accounts mostly reflected positive experiences in relation to CHNs. Second, the use of interpreters may further have influenced the level of detail regarding insight into families' "lifeworlds" as some meanings may have been lost in translations. As the study is done in a cross-cultural setting, the potential for loss of meaning is inherent to many other aspects as well, including how the families' understood the information letter and the meaning of giving consent to research. Despite we used trained interpreters with extensive experience, it may also be a limitation of our study that we had no professional audit of the quality of interpretations, for instance through a second interpreter. Third, there is a possibility of social desirability bias in the accounts of CHNs during their interviews, where they may have expressed their practices as more humanitarian than they actually were. Our participant observations may be a strength in the study, albeit CHNs may potentially have acted differently and in desirable ways, in the presence of the first author. Next, our insights are limited to the ethical care practices of CHNs within the DRC centers, and despite having highlighted the DRC context as enabling CHNs' care culture, we do not have insight into the practices of other DRC employees within the asylum centers. Finally, CHNs were gatekeepers to the families, and may have had their own selection criteria, and for instance might have avoided suggesting specific families for participation in our study. However, we believe this is a minor risk, as the interviewed families did show distress and powerlessness regarding the general asylum system, even though having positive or neutral accounts about the CHNs.

Conclusion

In this study, we have demonstrated how CHNs in asylum centers operated by the DRC are enabled to work within a profound humanitarian culture of care. Despite the pervasive uncertainty affecting asylum-seekers, and the complexity of caregiving in this context, we found that the humanitarian context enabled CHNs to provide comprehensive and crucial care for children and their families. It is apparent from our findings that CHNs' ethical care practices manifest themselves through compassionate, humanitarian, flexible, collaborative and supportive care for children and families seeking asylum. We argue that these five ethical care practices are constituent parts of respectful FCC and demonstrate cultural humility. As high-income countries continue to receive children and families who seek asylum, we hope our

findings will be heeded, and professionals encouraged to care in a respectful and family-centered way. Importantly, we also hope that these countries will focus on capacity building and an infrastructure that supports this type of care.

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Supplemental Material

Supplemental material for this article is available online.

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