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ORIGINAL ARTICLE

‘Valuable but incomplete!’ A qualitative study about migrants’ perspective on health examinations in Stockholm

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Background: A voluntary health examination is offered to asylum seekers in Sweden with the purpose of detecting infectious diseases and identifying other health needs. This study aimed to explore the organization, content and perceived value of the health examination from the perspective of asylum seekers.

Methods: Semi-structured interviews were conducted with 18 migrants recruited from different settings in Stockholm. Data were transcribed verbatim and analysed using thematic analysis in relation to the availability, accessibility, acceptability and quality framework.

Results: Participants reported positive aspects of the health examination while raising important concerns, categorized into the following themes: availability—despite being available, the service was considered to be delayed with perceived implication for infection control; accessibility—migrants experienced no physical or economic barrier to access the health examination, especially when it was performed through a mobile clinic, however, they had limited access to information; acceptability and quality—migrants trusted the health staff, however, the examination lacked important aspects related to mental health and dental care needs, among other health needs.

Conclusion: Health examinations are valued by participants but failed to identify and address many perceived health needs. Mobile clinics seem a practical strategy to improve accessibility.

Keywords: Accessibility, Examination, Health, Migrant, Refugee, Stockholm

Introduction

Forced migration and health

Migration is often associated with complex challenges on the social, political and public health levels for the individuals who move as well as for the hosting countries.[1,2] Being a migrant adds a particular dimension to the social determinants of health,[3] especially in the case of forced migration, where refugees and asylum seekers usually experience hard conditions during their travels and while waiting for legal decisions in the host countries.[4]

Refugees and asylum seekers have the right to the highest attainable standard of health similar to any other individual, a right that is protected by international conventions.[5,6] However, in practice, many migrants have restricted access to health care in the host countries, with great variation depending on the national laws and the legal status of the person.[7]

Health care for migrants in Sweden

Migrants in Sweden have different entitlements to health care according to their age and legal status. All children under the age of 18 y are entitled to full access to health care services. However, the rights of adults to health care differ according to their legal status, with asylum seekers having the most restricted rights confined to ‘care that cannot be postponed’, maternity care, abortion and family planning, while refugees with residence permits have the same rights to health care as citizens.[8]

Refugees and asylum seekers arriving in Sweden have different health needs and might require health care interventions without

further time delays, for example for mental health needs, infectious diseases and chronic conditions requiring immediate medical care.[9]

Health examinations for asylum seekers in Sweden

To identify urgent health needs of migrants and to control infectious diseases, Sweden offers a free-of-charge health examination to asylum seekers and refugees on a voluntary basis.[10] This examination is expected to provide information to migrants about the health care system in Sweden, perform an infectious disease screening through an interview and medical testing and identify any health problems that need immediate medical attention.[10] The migration office is mandated to inform asylum seekers about their right to a health examination and also funds the health examination. However, it is the responsibility of the health service to arrange the examination and send an invitation letter to the registered address.[11] The practical implementation of health examinations varies widely across and within regions and counties. The health examinations are usually performed at primary health centres, but can also be done through a mobile clinic where a team of nurses visits asylum accommodations.[11]

This study aims to explore the experiences and perspectives of asylum seekers regarding the organization, content and value of the health examination in order to inform policies and strategies to improve their coverage and quality.

Methods

Study design

A qualitative research approach with semi-structured in-depth interviews was used to explore the experiences and perspectives of asylum seekers.

Study settings and participants

Purposive sampling was used to recruit migrants residing in Stockholm county. Inclusion criteria included being either a current asylum seeker or a refugee with a residence permit, more than 16 y old and speaking one the following languages: Arabic, English, French, Swedish, Somali, Dari or Pashto. These languages are the most commonly spoken among recent asylum seekers. The participants were recruited from a Swedish for immigrants (SFI) school in central Stockholm, a language café, an asylum accommodation in southern Stockholm and through contacts that previously worked with asylum seekers.

In total, 18 adult participants (13 men, 5 women) were recruited and their ages ranged from 18 to 48 y. Three persons declined the invitation to participate in the study without clarifying the reasons. Participants came from seven different countries: Syria, Iraq, Somalia, Eretria, Afghanistan, Palestine and Tunisia. The majority (16) of the participants had been to a health examination, while two participants had not attended an examination at the time of the interview.

Data collection

Face-to-face interviews were conducted during November 2016 and February 2017 by JS, who is fluent in the following languages: Arabic, English, French and Swedish. Translators were used for Dari and Pashtu. The interviews were digitally recorded and lasted 20–25 min. A semi-structured interview guide was developed with the aim to explore the respondents' views and experiences systematically while keeping the focus on the main points of interest.[12] Additionally, probing techniques were used to encourage the respondents to clarify and elaborate on their perceptions. The interview guide was piloted before use. In addition, JS and AK met regularly during the process to discuss the interviews while identifying topics of special interest for further exploration.

Data analysis

Recorded interviews were transcribed verbatim by the first author in English and a thematic analysis approach was used for the analysis.[13] The recordings were listened to several times to ensure complete understanding of the transcripts. The transcripts were read and manually coded by JS and AK. The codes were discussed and sorted into potential categories. A set of categories was reviewed and classified under four pre-determined themes: availability, accessibility, acceptability and quality (AAAQ), which are the domains of the AAAQ framework. An example showing how the codes have been classified into categories and then a theme is shown in Figure 1.

The AAAQ framework domains, which are explained in Table 1, make it possible to analyse the current policy in a way that answers the research question. In addition, this framework was developed under the human rights convention that Sweden ratified and is therefore legally bound to implement.[14] For the stated reasons, the AAAQ framework is considered suitable for the analysis.

Ethical considerations

The study was approved by the Regional Ethical Review Board in Stockholm (2016/1648-32). Oral consent was obtained from the interviewees after introducing the interviewer and the purpose of the interview. Participants were informed that their participation was voluntary and that their identity and the data generated would be confidential. They were informed about their right not to answer questions or to terminate the interview at any time.

Results

The perspective and experiences of the participants in the health examinations fall under three themes: 'availability'—which reflects

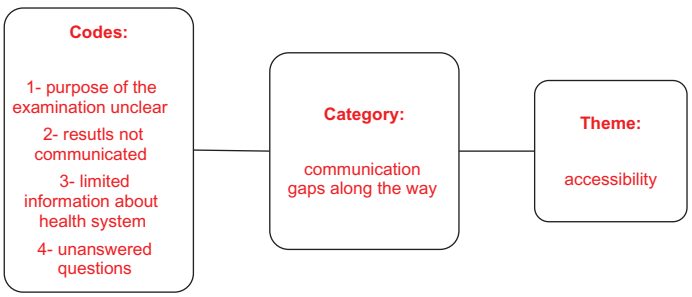

Figure 1. Example of a trail of the analysis.

Table 1. The AAAQ framework domains and definitions

Domain	Definition
Availability	Functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the state.
Accessibility	Health facilities, goods and services have to be accessible to everyone without discrimination. • Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups. • Economic accessibility (affordability): health facilities, goods and services must be affordable for all. • Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues.
Acceptability	Health facilities, goods and services must be respectful of medical ethics and culturally appropriate, and designed to respect confidentiality and improve the health status of those concerned.
Quality	Health facilities, goods and services must also be scientifically and medically appropriate and of good quality.

Source: United Nations Economic and Social Council, 2000. General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant). United Nations Committee on Economic, Social and Cultural Rights (CESCR), 2000.

the extent to which the service covers the target population; 'accessibility'—which highlights the physical/affordable access to the service and to the right information and 'acceptability and quality'—which brings attention to the ethical and cultural appropriateness of the service and the quality of its content.

Availability

Available but delayed

Health examination invitations were received by all participants expect one person. One person received the invitation but did not participate, mainly due to time constrains. Despite being offered an examination, most participants perceived the invitation as delayed, usually for several months after their arrival. They highlighted the importance of an early examination on arrival in order to detect infectious diseases and prevent transmission, especially in accommodation centres, as expressed below:

> *People should have been checked from the first day. We waited 2 months and we were always wondering when we will get checked…I know people who waited 8 months; this is a big mistake, as they will be in a bad situation by that time. (Male, Syria)*

Accessibility

Physical access facilitated by mobile clinic

The examination took place either at a health centre or at the accommodation centres through the visits of mobile clinics. For participants who lived in accommodation centres but had their examination at a health clinic, the transportation was facilitated by the worker at the accommodation centre, who explained the details of the trip to the participants. For the participants who lived at privately owned housing, they got help from relatives or the persons hosting them. The participants expressed that the health examination was easily accessible and they highlighted the importance of the mobile clinic initiative that facilitated their access to this examination.

> *It is good to do the examination at the camp; there are people who can't leave. It makes it easy for people so they don't go to the clinic. Some people have kids or other circumstances and therefore they won't go to the clinic unless it is an emergency. (Female, Syria)*

Affordable participation

Whether done in a health centre or through the mobile clinic, participation in the health examination, including transportation fees, was free of charge for all participants. Participants said that transportation was organized and paid for by the persons working at the accommodation centres. None of the participants mentioned any extra fee or economic burden associated with the health examination.

> *The personnel at the residence reception helped me; they took me to the clinic…I didn't have to pay anything. (Male, Afghanistan)*

Communication gaps along the way

Concerning the invitation letter for the health examination, some participants needed to rely on family members, friends or others to translate the letter from Swedish to their own language and they expressed a preference to understand it by themselves.

Some participants expected the examination to be a simple routine procedure while others expected it to be a full medical check-up. Some participants said they went to the examination with the idea that it was mandatory, while others said that they knew it was voluntary. However, the majority reported that they had no idea whether it was mandatory or not.

I didn't know if it is mandatory or voluntary, everyone was doing it so I thought I have to do it to know about my health status. (Male, Afghanistan)

The majority of the participants felt that the nurses did not give them enough information about the Swedish health care system, how they can get care and the costs. They also expressed that they need more information about how to prevent infections and about the common diseases they might be exposed to.

We were trying to squeeze information out of them; it was hard to get the information. They should give us the information and rules and policies of the system and they should tell us about our rights. (Male, Syria)

In addition, most of the participants did not know which diseases they were tested for, neither did they have access to the results of their laboratory tests if test results were negative. This was experienced as frustrating and made participants question the value of doing the tests.

As they took blood test, they should have told the people about the results. If I don't know the results of my blood test what do I benefit? (Female, Eritrea)

If the person is healthy, they should tell him that there is nothing to worry about, not leave the person without any message or anything. If the person has nothing worrying but he is not informed, the person stays anxious about the results. (Female, Somalia)

Acceptability and quality

Feelings of respect and trust

During the interaction with the nurse, participants felt respected and cared for. They also expressed trust in the medical team as 'they know what they are doing'. Participants were also satisfied with the translators to a large extent.

The interaction with the nurse was excellent, very good. (Female, Palestine)

Not an individual-centred process

Despite the acceptability of the infectious disease screening and laboratory testing, participants perceived the examination as very general with the same questions and procedures done for everyone. They expressed the need for a more individual-centred examination that focuses on the specific needs of the person. Participants considered the conversation with the nurse as a one-way communication where they did not have the chance to raise their own concerns and get answers for their important questions.

I had many questions, but I didn't get the exact answers. (Male, Iraq)

Actual needs go beyond infectious diseases screening

Participants perceived checking for infectious diseases through a blood test as the main focus of the examination. They expressed general dissatisfaction with the content of the examination, as it did not cover their major perceived needs, including mental health and dental care. They also questioned the significance of asking about diseases while no effective treatment could be offered to them following the health examination mainly due to their asylum status.

They do this examination to know about your health condition…but anyway, if you have some problem they don't treat you, they say you don't have a residence permit and you have to wait. (Male, Afghanistan)

Physical examination, a missing element

Participants considered a physical examination an important element that should be performed to check for any physical symptoms and reassure them about their health; however, for the majority this was not the case.

The nurse didn't touch me with her hand at all. She didn't examine me with anything. It should be a more stringent procedure, because maybe we are carrying a disease and we don't know! (Male, Syria)

Discussion

This study shows that due to the lack of a physical examination and active communication, the health examination did not capture all perceived needs of the migrants, which, from the user perspective, compromises the quality of the service offered. Mental health, dental care and timely preventive measures to limit transmission of infections were the main unmet needs identified through this study. Moreover, there is a need to ensure better communication and provide clear explanations about the scope and purpose of the examination, as previously highlighted for this target group.[15] This study also raises the dilemma of identifying mental or somatic diseases while not offering treatment for immigrants due to their legal status. Treatment of infectious diseases is offered free of charge to asylum seekers in Sweden, but care for mental or chronic conditions may not be offered, depending on the severity and local traditions. The restriction of health care entitlement raises an ethical question about the concept of equity in health and the right to health care for most vulnerable groups without discrimination.[3,14]

The mobile clinic has been shown to be a welcome concept for the immigrants, as it simplifies the process for them, as mentioned mainly by participants who belong to families with many members or members with disabilities. This study suggests further adopting the mobile clinic strategy in order to cover a large number of immigrants living in the same accommodation centre. Our results are consistent with previous literature where mobile clinics have been identified as one of the promising strategies and interventions to increase access to health care for vulnerable groups and migrants, as it removes the geographic and social barriers associated with fixed health care settings.[16,17]

The finding that information was insufficient highlights the need to develop a better system to share information with immigrants about the purpose of the health examination itself, the Swedish health care system and their entitlements and rights in the new country, since unclear or missing information led to different expectations, unfulfilled needs and confusion about the health care system. In addition, participants reported that they received little information about which diseases they were tested for and the results of these tests. As it has been shown in other studies as well, this lack of information can result in anxiety and frustration among the migrants.[18,19] In this way, the current practices may be considered a missed opportunity to communicate with the newcomers about diseases and prevention.[20,21]

The health examination was available to the majority of the participants and seems to be culturally appropriate, leading to high acceptability of the service among the participants. This positive attitude was expressed by everyone, whether they thought it was a voluntary or mandatory procedure, a point that was reported by previous studies as well.[19,20,22] However, we argue that the time delay between entering Sweden and screening raises a question about the value of screening for diseases mainly in terms of infection control, even though these delays may reflect local implementation limitations rather than national laws and policies, as is the situation in other European settings as well.[15] From a broader perspective, infection control among asylum seekers and refugees is a topic that is addressed differently in different European Union (EU) countries. Recent policy analyses show the challenge of designing timely and cost-effective infection screening programmes in the EU for these vulnerable groups and highlight the policy variations within and between the countries. Therefore the challenges with infectious control strategies seem to apply even beyond the Swedish setting.[23,24]

Methodological considerations

Our findings cannot be generalized to other groups or any international settings; however, previous studies conducted in Sweden obtained similar results, suggesting that the results might be transferred to other Swedish settings where the health care system and polices are the same.[19,20,22]

The preliminary results have been debriefed in a seminar with the nurses conducting health examinations in Stockholm and other stakeholders who have exchanged with us their experiences with the same target group. These discussions supported and reinforced our findings.[25]

The limitations due to language and translation problems were minimized since the researchers conducted most interviews in languages they are fluent in, without a translator. The translation has been checked by AK to minimize bias. Experienced translators with Pashtu and Dari as mother tongues were recruited. However, some information might have been lost during the process of translating.

Discussions between the authors throughout the data collection and analysis led to some enhancement of the interview guide throughout the process. The data have been analysed by the researchers, who have different backgrounds with clinical and public health expertise, thus triangulation of researchers has been achieved, contributing to the trustworthiness of the study.[25]

Conclusion

Migrants value the health examination offered to them, especially when it is done through a mobile clinic at their own accommodation. However, more focus should be put on non-communicable diseases, mental health and dental care to capture the actual needs of this population. The way the examination took place leaves some important questions unanswered for the users, a problem that should be addressed to increase the potential benefit of this service in the future.

Authors' contributions: The study was designed and planned by all three authors. JS carried out the interviews, analysed data and drafted the manuscript. AK participated in enhancing the interview guide, coding and analysis of the results and drafting the manuscript. JS, AS and KL conceptualized the study and participated in drafting the manuscript. All authors read and approved the final manuscript.

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