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From Immigrant to Patient: Experiences of Bosnian Immigrants in the Swedish Healthcare System

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ABSTRACT

Background: We aimed to explore the background of refugees emigrating to Sweden and their situation in the new country with special focus on their contacts with the Swedish healthcare system. **Material and methods:** Our study has a qualitative design. Data was collected between January and October 2013 during face-to-face interviews using open-ended questions. A qualitative content analysis was carried out in accordance with the Graneheim and Lundman method (2004). The participants were 8 women and 7 men, aged between 65 and 86 years who had emigrated from Bosnia and Herzegovina. They had lived in Sweden between 13 and 21 years. **Results:** The findings revealed that the participants themselves experienced that change of scenery, culture and language influenced their own well-being. The most important finding was that language and communication difficulties are experienced as the major problems. These difficulties implied that all informants were forced to seek help from their children or to use an interpreter when they visited various healthcare institutions. **Conclusions:** Health care professionals need to be aware of the diverse needs of various ethnic groups in Sweden, some of whom may carry traumatic experiences that could influence their health. In order to provide trans cultural care, a professional staff needs to know that historical, political and socioeconomic factors may influence ethnic minorities. Health care staff needs to recognize that social problems might be medicalized. In particular this article emphasizes the problems associated with language.
Key words: Refugees, war, Bosnia and Herzegovina, healthcare system, language, experiences.

1. INTRODUCTION

Every year millions of people move from their homes and resettle in other countries as an effect of globalization, war, natural disasters, politics and family relations. The most common reason for immigrating to Sweden has been political, but family relations are also important (1). Bosnia and Herzegovina is a part of the Balkan region, and was geographically and politically bonded with the former Yugoslavia until 1991, at which time it became an independent state, after a period of war. Many Bosnians lost their lives in the war, and other survived by fleeing. Between 1992 and 1995, the people of Bosnia and Herzegovina experienced one of the most terrible wars seen in Europe since the end of World War II. Violence and ethnic cleansing were deliberately used as a tool to drive people from the areas where they were born and had lived for generations (2). The whole social structure was destroyed and there was no adequate social support system. In the same war, the civilians of Bosnia and Herzegovina were exposed to extreme threats and intense feelings of helplessness (3,4). The traumatic events experienced by thousands of people during this conflict may have a lasting effect on the mental health of the country (5). They have also had impact abroad as negative health consequences are especially high when relocation is due to severe conflicts, associated with violence and trauma (6).

Since the 1970s, immigration has increased in Sweden as well as in many other European countries. Immigration is now the main source of an increasing of the number of Swedish population. Only in 2006, 86,436 immigrants were granted residence permits in Sweden, of which 25,096 were for protection or humanitarian reasons (7). Refugees, unlike many immigrants who have left their homes for economic reasons or to join family members already settled in another country, have fled in order to survive. Most of these people have faced difficult transit experiences, culture shock, adjustment problems related to language and occupational change, and disruption in their sense of selfhood and community in the resettlement country (8). Additionally, a refugee has often suffered multiple losses such as severance from family and friends.

Trans cultural nursing is an essential aspect of healthcare today and this is a new concept and a separate area in nursing science (9, 10). In developing the theory, a major hurdle for health professionals was to discover meanings, practices and factors influencing care by religion, politics, economics, world view, environment, cultural values, history, language and gender. These factors needed to be included for culturally competent care. The nursing profession has adopted this concept. Nurses and health professionals describe cultural competence as having the ability to understand cultural differences in order to provide quality care to a diversity of people. Cultural competence involves nurses and health professionals continuously striving to provide effective care within the cultural confines of their patients. The central purpose of this theory is to discover and explain diverse and universal culturally based care factors influencing the health, well-being, illness or death of individuals or groups. The purpose and goal of the theory is to use research findings to provide culturally congruent, safe and meaningful care to clients of diverse or similar cultures. The three modes for congruent care, decisions and actions proposed in the theory are predicted to lead to health and well-being or to face illness and death. In sum, the Culture Care theory has been a major and significant contribution to establish and maintain the discipline of trans cultural nursing discipline over the past five decades. The holistic and particularistic features and the ethno nursing method have led to a new body of knowledge about culture and care phenomena. Having knowledge of the patient's cultural perspectives enables the nurse to provide more effective and appropriate care (9, 10). The language plays a central role in communication and interpretation of the culture, and it is important that nurses and health professionals first understand their own cultural values, attitudes, beliefs and practices that they have acquired from their own families before learning about other cultural ways (11). Healthcare systems and patients are to a variable extent influenced by the local culture. This means that the way to express symptoms of disease and the expectations of the patient and on the patient by healthcare providers differ between regions, which may cause problems when an immigrant calls for medical attention in a new country (12, 13, 14, 15).

The Swedish health care system is expected to provide equal health care opportunities for all patients (16). The Swedish Health and Medical Services Act (1982) stipulate that health care must:

- Be of good quality and take account of the patient's need for safe care and treatment,
- Be readily available,
- Be based on respect for the self-determination and privacy of the patient and
- Promote good relationships between patients and health care providers.

Previous studies about the healthcare system among refugees showed that immigrants in Sweden have significantly poorer health than native Swedes (17). And may therefore have increased need for healthcare services (18, 19).Previous studies made in Sweden about refugees coming from Burundi, Colombia, Iraq, Kazakhstan, Poland, Kosovo and Syria, showed that the main problems were related to feelings of being uninformed and being sent to various levels of care, which resulted in lack of trust, and feelings that no one took overall responsibility (20).

The aim of the present study was to describe the life of Bosnian immigrants after arriving to Sweden, with focus on contacts with healthcare system.

2. SUBJECTS AND METHODS

Our study is based on a qualitative design, as the study aimed to describe and analyze how patients experienced the Swedish health system. Inclusion criteria were subjects/persons coming from Bosnia and Herzegovina, who were more than 60 years old, had lived in Sweden more than 10 years and had visited the healthcare canter more than twice during the past month. Twenty subjects/persons were invited to participate in the study, of which 15 participants agreed to participate. Three of the participants declined participation without explanation and two of participants moved back to Bosnia and Herzegovina during the study period. Accordingly, fifteen persons participated in the study: eight women and seven men, aged between 65 and 86 years. All participants had lived in Sweden between 13 and 21 years (Table 1). The first author of the study (NS) made appointments for all interviews.

Data was collected through individual face-to-face interviews by the first author (NS) using open-ended questions, following an interview guide inspired by Kvale (21). The interviews were performed between January and October 2013. They began with small talk. The opening question was" *Can you please tell me about your life after arriving to Sweden?"* and *"Could you please tell me about your experiences to being a patient in Sweden?* The initial question were supplemented with other short questions like "*Could you please tell me more about this?* or "*What do you mean whit this?* All contacts with the informants were arranged in collaboration with one key person in the Bosnian association of Gothenburg, located close to the place where the participants lived. Information concerning the aim and background of the study was printed and distributed to the informants, and repeated to them orally before the interview. The interviews were individual and held in the participant homes. Participants were encouraged to speak freely using their own words and the interviewer encouraged the informants to respond to questions as comprehensively as possible. The interviews were carried out in Bosnian by the second author, who is bilingual. All interviews were translated first into Swedish by the second author, and the translation was checked by a professional translator. The interviewer only interrupted for questions or for following-up the information given. The interviews lasted between 60 and 90 minutes and were taped, transcribed and transcribed verbatim. The audio-recorded interviews were transcribed verbatim and analyzed in accordance with Graneheim and Lundman (2004). Due to the nature of our study, a qualitative dynamic analysis method that stays close to data was needed. In this context a qualitative content analysis method in accordance with Graneheim and Lundman chose for analysis and interpretation of the collected data. This method is capable to condense a large amount of data to a limited number of themes, categories, subcategories and codes. Furthermore, content analysis method makes it possible to include interpretations of a latent content The transcripts were read carefully in order to identify the informants' experiences and conceptions of the migration and its effect. Then, the analysis proceeded by extracting meaning units consisting of one or several words, sentences, or paragraphs containing aspects related to each other and addressing a specific topic in the material. Then meaning units related to

Informants	Sex	Age	Years in Sweden	Employment Yes / No	City of birth	Number of visits to the healthcare canter/month
1	F	65	14	No	Banja Luka	5
2	M	67	15	No	Sarajevo	3
3	M	68	13	No	Prijedor	4
4	F	76	14	No	Sanski Most	3
5	M	81	17	No	Gorazde	4
6	F	63	12	No	Rudo	3
7	F	66	13	No	Rogatica	3
8	M	73	15	No	Brcko	4
9	M	75	12	No	Travnik	5
10	M	79	16	No	Srebrenica	3
11	F	82	17	No	Zvornik	4
12	F	70	13	No	Mostar	3
13	F	86	18	No	Skender Vakuf	5
14	F	77	13	No	Zenica	3
15	M	69	14	No	Tuzla	3

Table 1. Demographic data of informants

each other through their content and context were abstracted and grouped together into a condensed meaning unit, with a description close to the original text. The condensed text was further abstracted and labelled with a code. Thereafter, codes that addressed similar issues were grouped together, resulting in subcategories. Subcategories that focused on the same problem were brought together, in order to create more extensive conception*s*, which addressed an obvious issue (22). The results are presented with direct quotes from the interviews. According to the Swedish law, there is no need for an ethical board review if written consent has been obtained from the participants and if there is no physical intervention involved in the study (23). However, the study conformed to the principles outlined in the Declaration of Helsinki (24). Participants were informed that participation was voluntary and that confidentiality would be maintained. Written informed consent was obtained from the participants.

3. RESULTS

The analysis resulted in one category and four subcategories depending on how the participants described their lives in Sweden. The category, together with the subcategories, are presented in Table 2. Although this article is primarily concerned with the participant's experiences in Sweden, several questions concerned their lives in Bosnia and Herzegovina. Informants in this study told us freely about their experiences before arriving in Sweden, about their life in Sweden and experiences during the visits to the healthcare centres. The interviews were then analyzed in terms of different themes or subcategories (Table 2).

3.1. Life in Sweden

As a consequence of everything happening in the world today you can no longer decide where to live. To become refugees and immigrants in a foreign country is difficult and has its consequences. In the interviews it was found that older people found it especially hard to come to another country after leaving everything, their homes, their children, their relatives and friends, and all their property. None of the informants thought of themselves as Swedish. The culture and environment were perceived as strange, which they all felt contributed to their health and well-being deteriorating.

3.1.1. The refugee centre

Categories	Subcategories
The life in Sweden	The refugee centre
	The language barriers
	The children's help
	Having gratitude in/to Sweden

Table 2. Overview of the categories and subcategories

On arriving to Sweden, all of the informants were placed in refugee centres and sent around Sweden. This was experienced in different ways.

"I lived in a house with refugees from around the world. There was no one from Bosnia and Herzegovina. It was terrible; I did not feel well and considered to returning to Bosnia".(p3)

A woman described her time in the centre as follows:

"I was very ill and needed medical attention. I was very afraid. The ambulance came. The doctors talked and talked, explained, discussed with me and themselves ... I just looked at them and did not know if I should laugh or cry".(p4)

"I was in a house with refugees from Somalia. Every day I only watched TV. It was no fun".(p1)

3.1.2. The language barriers

Coming from a country that is at war, and all the problems associated with this situation was emphasized by all the informants in our study as reasons not to get involved and learn the Swedish language. All had hoped that the war would end in a few months so that they could return to their home country. None of the informants knew more than a few Swedish words and were thus unable to communicate in Swedish. This also means that the informants lacked the social skills that could connect them with Swedish society. All informants are very sorry today that they never learned the Swedish language.

One participant described his language experiences like this:

"Knowing a language is a treasure. I often meet older foreign persons on the street who want to ask me something. They talk incessantly, but I understand nothing".(p2)

All the informants described when they were out walking, how they were assisted in the Swedish language by their children, grandchildren or friends. This meant that informants became more passive and did not care about their communication difficulties because there was always someone available who could help them with translation. At the same time it happened that

the children were the ones who suffered most because they had to plan both for themselves and their families.

Communication difficulties were described as follows:

"My neighbors are Swedes, two elderly women who are very nice. Oh God, how I regret that I did not study Swedish. We would have had so much to talk about and it'd be great fun, but now we cannot".(p5)

Language and communication barriers can lead to various difficulties and challenging situations. All informants had situations where they felt uncomfortable, laughed and felt as if they had lost their personal worth, a situation which is described in the following:

"Two years ago I broke my hip, went to the hospital and met a Swedish physician. I explained through the interpreter that I was a doctor, but he did not hear or did not want to hear".(p8)

Another participant described her situation like this:

"My son's wife is Swedish. She often comes to us and we have so much to talk about. The problem is that I can't speak Swedish language".(p7)

An interpreter was sometimes hired to deal with different situations where informants must communicate in Swedish but could not. In the health care services, for example, three of the informants felt that it was much more sensitive to talk about their symptoms if another person was present. Medical staff unassisted by a professional interpreter cannot be sure that the patient is given the opportunity to express their views completely. However, during the interviews it was revealed that the interpretation situations caused a variety of problems. The interpreter did not speak the same language, did not translate correctly, sometimes they were not on time for an appointment, and it took a long time to get a translation. These were just some of the points that all respondents were dissatisfied with.

About their experiences with interpreters one participant said the following:

"Once we needed an interpreter and he came. He was from Kosovo and did not know the Bosnian language. We must teach him Bosnian so he can translate into Swedish. It was not funny". (p6)

Another woman said:

"I take my son's daughter with me always. We understand each other very well. She is the best".(p11)

About keeping times, one informant described the situation as follows:

"I had an appointment with the doctor. The interpreter did not come, but who cares?".(p10)

Among the respondents, there were some who had difficult experiences from the war in Bosnia and Herzegovina and did not want an interpreter. Some of the informants did not want to accept that they speak Serbo-Croatian language, only the language of the country they come from. One participant describes their problems as follows:

"I made an appointment and said I wanted an interpreter who spoke Croatian. When I got to the doctor it was a Macedonian interpreter. He said he spoke Serbo-Croatian, maybe he did, but I understood nothing. We booked another appointment and waited another month which was no good. Then came a Croatian interpreter and it went well".(p9)

One informant had the following to say about language:

" With Yugoslavia's disappearance the Serbo-Croatian language disappeared, and then there will be Serbian, Bosnian, Slovenian, Macedonian, Croatian and other languages of the former Yugoslavia".(p12)

3.1.3. The children's help

All respondents thought it obvious that children should help their parents who live in Sweden but cannot speak Swedish even if it usually led to encroachment on the child's privacy.

One participant described the relationship with his/her children like this:

"My children and I live next door to each other. It feels really good. I'm really happy to have my children here".(p15)

One participant described his relationship with his children in Sweden like this:

"Asking for help from my children would mean that I intervene into their lives, but I must. I'm sorry, but I have to".(p13)

One participant said:

"My children call me daily. I have the nicest kids in the world". (p14)

3.1.4. Having gratitude in Sweden

All respondents found it difficult to move from their home country, leaving everything, to a completely different country. This was experienced as something terrible. When it comes to being thankful that they were allowed to stay in Sweden, emotions were mixed and informants had different opinions on the issue.

One informant said:

"We have always paid 50 % tax for our work in Bosnia and Herzegovina. Today I have a pension which is 2000 SEK per month. What should I be grateful for?"(p4)

Another said:

"We must adapt to Swedish society and thus thank Sweden and the Swedes for all the help we received and are still getting here".(p8)

Even stronger feelings appeared on the question of debt of gratitude:

"Who has something bad to say to the good country that took care of us? If we lived in Bosnia and Herzegovina now, we would fight for our survival. Sweden is best for older people who cannot fend for themselves".(p11)

4. DISCUSSION

In this study we analyzed experiences of the immigrants from Bosnia and Herzegovina. We found that the change of scenery, culture and language influenced the well-being of the informants. During the war, the majority of informants were forced to leave their property, They were separated from their children and had to leave their work and social community thereby leaving language, their homeland and what they so far had experienced during their lives behind. Language and communication difficulties were felt to be the major problems.

Based on our results, we could see that the informants perceived well-being in their home country when they lived in their own environment. There they lived with their own culture and spoke their own language. Having a job, taking care of the family and taking part of the social community was perceived as very positive. From having an active and fulfilling life, all informants switched to a less active and more isolated life. Some of the informants experienced the war and were both mentally and physically tortured. All informants felt a great loss of all those belongings they had left in their previous world.

According to the participants in the interviews, their well-

being deteriorated when they became refugees in Sweden. According to Andersson (25) this may be the result of settling in a foreign country, which brings experiences of alienation; of a lack of identity and rootlessness. Despite the fact that the informants moved to another country, they had not left their culture and the social communication. None of the informants could be socialized into the new society. None of the informants were able to understand the new language, or convey information in Swedish. Not being able to understand and make them understood was experienced as negative by all informants. All informants also regretted that they had never learned the Swedish language. According to Magnusson (26) the relationship between culture and communication is intimate and it is through communication that culture is passed on. Culture itself influences how we express our feelings, as well as ourselves verbally and non verbally. Without knowledge in Swedish language the informants were not able to have Swedish friends and without them the informants cannot learn the Swedish culture. The findings in our study are in the line with other studies which showed that some participants could not access information because they were unfamiliar with the structure of the Swedish healthcare system. Lacking linguistic skills and difficulties in communication with care providers, for example regarding information about their disease and involvement in treatment, caused frustration and increased the risk of misunderstandings, miscommunication and inequalities in healthcare provision (27, 28, 29).

All of the informants belonged to the same cultural-geographical area. The fact that they were forced to live in another country eliminated their cultural and historical background, which had a negative impact on their social situation. Language limitations and communication difficulties meant that all informants were forced to seek help from their relatives or had to use of an interpreter when they visited various institutions. Our findings are also in line with a study of Chinese and Vietnamese patients living in the USA. Ngo-Metzger et al (30) showed that using an interpreter could even exacerbate disparities in patient's perception of their providers, despite receiving more information compared to those without an interpreter. Thus, an interpreter could not substitute a language-concordant provider (30). According to Gerrish (27) the quality of care is affected if the hospital does not have the opportunity to hire a professional interpreter, and allows children to interpret for their parents or relatives. He further argues that such interpretations are filled with feelings, misunderstandings, wrong interpretations and misinterpretations of the diagnosis and treatment resulting in detrimental medical misunderstandings.

On the other side Öhlander (31) described that patients with immigrants background risk being described as "problematic" patients because that healthcare professionals treat the patients group based on stereotypical images of how a patient from another country is supposed to act, think about care, need, so as the emphasis on cultural diversity might lead to exaggerated differences. One limitation of our study was that we interviewed the participants in their homes, and sometimes (in the three cases) the participants had guests. In two other cases children of the participants joined the participants during the interview period. These circumstances may have affected the answers and may have made the participants less open.

5. CONCLUSION

The data in our study showed several major areas to improve access and quality of life for Bosnian refugees in Sweden. These areas are particularly concerned with language and cross-cultural communication and improvements could be made by organizing different meetings for Swedes and immigrants from Bosnia and Herzegovina, organizing various courses in Swedish for immigrants where they live, informing Bosnian immigrants more about the Swedish culture and the Swedish health system and increasing the budget to train more interpreters in the Swedish language. These are only a few areas that should be improved to make immigrants from Bosnia and Herzegovina feel better psychologically and physically.

Sweden is today a multicultural and multi ethnic society. Health care systems and patients are to a variable extent influenced by the local culture. This means that the way symptoms are described, the expectations of the patient, and the expectations that health care providers have on patients differ between regions, which may cause problems when an immigrant calls for medical attention in a new country. Health care professionals need to be aware of the various ethnic groups in Sweden. Hence, health care system must adjust to the needs of ethnically diverse patients instead of the other way around. In order to provide trans cultural care, professional staff needs to know that historical, political and socioeconomic factors may influence ethnic minorities groups in Sweden. Effective and simple routines and facilities are also necessary when communicating with patients speaking a foreign language. Health care staff needs to recognize that social problems might be medicalized and to develop a deeper understanding of the individual and how to meet individual needs in the light of immigrational and cultural background that might influence health.

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