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# **An explorative study of the protection of health for asylum seekers in Sweden in relation to health as a Human Right**

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A Swedish Red Cross report 2008 by Maria Stålgren



## PREFACE

I would like to remind the reader of the preamble of the Universal Declaration of Human Rights (1948); “... *recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world*” (p.71).

To protect health is to protect dignity, and this protection is important for so many aspects of our lives within a complex society in a globalized world. The introduction of this report gives a quite detailed description of health as a human right as well as a description of migrants, who are they by definition? If you are familiar with this combination of topics, skip reading the introduction. But for all of you who are either familiar with health or Human Rights or migrants I wish to share with you months of reading to understand the complexity, challenge and possibilities of the protection of health as a human right for one group of migrants: asylum seekers. This is not at all a text with all the answers but hopefully it will facilitate your and mine capacity and knowledge to increase the protection of health in our daily activities. The summary, method, results and the discussion of this report will speak for itself.

The author of this report has been supervised by Associate Professor Solvig Ekblad, and Professor Lars Åke Persson.

The European Refugee Fund has co-financed the study as a part of the Swedish Red Cross project “*Survey and dialog for the purpose of health promotion in asylum seekers*”.



I wish to express my gratitude to everyone who has assisted me in one way or another to make this work a reality. I want express a comment from several participants in the study “*I hope this study will make a change*”.

Stockholm December 2008  
Maria Stålgren

For more information: [www.redcross.se/prohealth](http://www.redcross.se/prohealth)

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Special thanks to Lars-Åke Persson, Professor at IMCH, Uppsala University for being my assistant supervisor. Thank you for sharing your great knowledge of important aspects of international health and for your perspectives, patient and support throughout the process.

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Stockholm September 2008  
Maria Stålgren  
Registered Nurse

## ABSTRACT

Background: In 2005 the Swedish Red Cross expressed the need to improve the health of asylum seekers and voiced concern that the right to health is not obvious to asylum seekers in Sweden. This report presents the first results of the Swedish Red Cross project, “*Survey and dialogue for the purpose of health promotion in asylum seekers*”. The study focuses on the protection of health for asylum seekers on an individual, community, organisational and public policy level in Sweden. The aim of the study is to explore possible threats, effects of threats and actions to take to increase the protection of health.

Method: This is an explorative qualitative study based on 28 semi-structured interviews with 12 participants from the Swedish Migration Board and 16 from the Swedish Red Cross, as a total geographical investigation of Sweden. This study was approved by the regional board of Vetting the ethics of research involving humans in Stockholm, May 2007, record number 2007/206-31. The findings from individual interviews are analysed with qualitative conventional content analysis.

Results: Two main themes are identified: Threats to the protection of health for asylum seekers in Sweden. The threats are presented with six sub themes that are all threats to asylum seekers’ health; the legal framework, assessment of health care needs, financial aspects of health care, geographical disparities in health care, gatekeepers and care access and the final identified threat is availability to access. Each threat is explored with; identified threats, effects of threats, explored action to take against threat. The second main theme is staff needs of support to protect health with sub-themes of participants’ education in Human Rights and their supervision. Several findings indicate action that would protect health; the major one being changes to legislation currently limiting access to care. There are geographical disparities concerning care access for torture survivors, patients with mental illness as well as infectious diseases. Children are sometimes denied access. Co-operation and personal contacts between organisations increase access.

Discussion: There is a gap between the current access to health care for asylum seekers in Sweden and the protection by international legislation (ratified by Sweden) that expresses health as a human right. Asylum seekers are refused health care on different levels, from the individual level to the public policy level, due to legal restrictions. The denial of health care is a threat to asylum seekers’ dignity and health.

Conclusion: To increase the protection of asylum seekers’ health and dignity it is necessary to make interventions on different levels: public policy – remove the legal restriction to access; organisational and community level– provide access to specialised care in all parts of Sweden, especially to vulnerable groups such as torture survivors and patients with mental ill health. For asylum seekers in general and especially for children and patients with infectious diseases, there is need to improve routines to facilitate access. Staff request training in Human Rights with a practical “tool-kit” for their daily work. Supervision for staff/volunteers in meeting asylum seekers’ needs and dealing with their uncertain life situations is important. More evaluation is required regarding what kind of supervision fulfils the objectives. Encouraging findings are participants’ experiences of facilitating gatekeepers increasing access to care as well as co-operation between different bodies.

Key words: right to health, health, asylum seeker, Human Rights, access to health care, Sweden, total geographical investigation

## SAMMANFATTNING

Bakgrund: 2005 beslutade Svenska Röda Korsets riksstämman att göra en kraftansträngning för att förbättra asylsökandes hälsa eftersom rätten till hälsa är inte självklar för asylsökande i Sverige. Det här är presentationen av de första resultaten av Svenska Röda Korsets projekt; ”Kartläggning och dialog för att främja asylsökandes hälsa”. Projektet är delfinansierat av Europeiska Flyktingfonden. Studien fokuserar på skyddet av hälsa för asylsökande i Sverige. Studiens syfte är att på individ, organisation/samhällsnivå samt policynivå utforska eventuella hot, effekt av hoten och åtgärder att vidta för att öka skyddet av asylsökandes hälsa.

Metod: Det är en explorativ studie baserad på 28 halvstrukturerade intervjuer med 12 deltagare från Migrationsverket i Sverige och 16 från Svenska Röda Korset. Studien är gjord som en total geografisk inventering i Sverige. Resultatet är analyserat med kvalitativ innehålls analys. Studien är godkänd av regionala etikprövningsnämnden i Stockholm i maj 2007, diarienummer 2007/206-31.

Resultat: Två huvudteman har identifierats som resultat. Första huvudtemat är Hot mot skyddet av hälsa för asylsökande i Sverige. Hotet är presenterat med följande sex underteman; det lagliga ramverket, bedömning av behovet av hälso- och sjukvård, finansiella aspekter på hälso- och sjukvård, geografiska skillnader på tillgänglighet till hälso- och sjukvård, dörrvakter för/mot tillgänglighet, möjlighet till tillgång på vård. Varje undertema är utforskat med: identifierade hot, effekt av hot, utforskade åtgärder att vidta mot hotet. Det andra huvudtemat är: Personalens behov av stöd för att skydda hälsa med följande underteman: utbildning i mänskliga rättigheter samt handledning. Flera resultat visar på åtgärder att vidta för att skydda hälsa. Det främsta är att förändra den lagliga begränsningen av tillgång på vård. Det finns geografiska skillnader på tillgänglighet till vård för tortyr överlevare, patienter med psykisk ohälsa samt oklarheter kring behandling av infektionssjukdomar. Barn nekas ibland vård. Samverkan och personliga kontakter mellan aktörer ökar tillgängligheten till vård.

Diskussion: Det är ett önskat mellanrum mellan tillgängligheten på vård med den nya lagen om hälso- och sjukvård för asylsökande i Sverige jämfört med den internationella rätten som inbegriper hälsa som en mänsklig rättighet och som Sverige ratificerat. Nekandet till hälso- och sjukvård för asylsökande sker på olika nivåer i den enskildes sammanhang; från policynivå såsom den restriktiva lagen, till individnivån. Nekandet till hälso- och sjukvård för den asylsökande är ett hot mot asylsökandes värdighet och hälsa.

Slutsats: För att öka skyddet av asylsökandes hälsa och värdighet är det nödvändigt att vidta interventioner på olika nivåer. På policy nivå bör den lagliga restriktionen till vård tas bort, på organisatorisk och samhällsnivå behövs tillgång till specialiserad vård i alla delar av Sverige speciellt till utsatta grupper såsom tortyr överlevare och patienter med psykisk ohälsa. För asylsökande i allmänhet samt speciellt för barn och patienter med infektionssjukdomar behövs förbättrade rutiner för att underlätta tillgänglighet. På individnivå, för stöd till personal och frivilliga är det efterfrågat med en ”verktygslåda” för de mänskliga rättigheterna i det dagliga arbetet. Det är viktigt med handledning till personal/frivilliga för att kunna möta asylsökandes behov och deras osäkra livssituationer. Utvärdering behövs kring vilken handledning som uppfyller målen och behoven. Upplyftande resultat är deltagarnas erfarenheter med underlättande ”grindvakter” som ökar tillgänglighet till hälso- och sjukvård samt samverkan mellan olika aktörer.

Nyckel ord: rätt till hälsa, hälsa, asylsökande, mänskliga rättigheter, tillgänglighet till vård, Sverige, geografisk totalundersökning

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## LIST OF ABBREVIATIONS & EXPRESSIONS

### Abbreviations

**CESCR:** International Covenant on Economic, Social and Cultural Rights

**ERF:** European Refugee Fund<sup>1</sup>

**ICRC:** International Committee of the Red Cross

**IFRC:** The International Federation of Red Cross and Red Crescent societies<sup>2</sup>

**IMCH:** International Maternal and Child Health (Uppsala University)

**MB:** Swedish Migration Board

**NGO:** Non Governmental Organisation

**OHCHR:** The Office of the High Commissioner for Human Rights

**SEK:** Swedish currency 9.49 SEK= 1 € , 6.07 SEK = 1 US \$<sup>3</sup>

**SRC:** Swedish Red Cross

**UN:** United Nations

**UNHCR:** The United Nations High Commissioner for Refugees

**UNTS:** United Nations Treaty Series

**WHO:** World health organization

### Expressions

#### English

Accommodation provided by the Migration Board where MB staff are responsible and accessible

Bodies<sup>7</sup>

”Care that cannot be deferred”

- is an legal expression of a level of access to care for asylum seekers in Sweden

Decree

Defer (postpone)

Defer = wait before realising

Governmental Bill

”Independent accommodation”, means asylum seekers living with relatives or friends

Voluntary Health Control

The Migration Courts

Migration Court of Appeal (Reviews

Migration Board decisions<sup>5</sup>)

Permanent residence permit

#### Swedish

anläggningsboende (AB0)

Migrationsverket (MV), boende där det finns MV personal ansvarig och tillgänglig

aktörer

”vård som inte kan anstå”

- är ett lagligt uttryck på en nivå av vårdtillgänglighet för asylsökande i Sverige

förordning

anstå (uppskjuta)

anstå =vänta med att förverkligas<sup>4</sup>

lag proposition

eget boende (EBO) (I praktiken “inneboende”)

Hälsosamtal

Migrationsdomstolarna

Migrationsöverdomstolen (prövar

Migrationsdomstolarnas beslut)

permanent uppehållstillstånd (PUT)

<sup>1</sup> [http://ec.europa.eu/justice\\_home/funding/refugee/funding\\_refugee\\_en.htm](http://ec.europa.eu/justice_home/funding/refugee/funding_refugee_en.htm)

<sup>2</sup> The Red Crescent is used in place of the Red Cross in many Islamic countries. Source: [http://www.ifrc.org/who/index.asp?navid=03\\_01](http://www.ifrc.org/who/index.asp?navid=03_01)

<sup>3</sup> source: [www.forex.se](http://www.forex.se) 24 May 2008

<sup>4</sup> Source; National Encyclopedia

[http://www.ne.se.ezproxy.its.uu.se/jsp/search/article.jsp?i\\_art\\_id=O105374&i\\_word=anst%e5](http://www.ne.se.ezproxy.its.uu.se/jsp/search/article.jsp?i_art_id=O105374&i_word=anst%e5)

<sup>5</sup> <http://www.migrationsverket.se/english.jsp> or <http://www.migrationsverket.se/>

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# 1. INTRODUCTION & BACKGROUND

## *Introduction*

This Master thesis presents the first results of the Swedish Red Cross project: “*Survey and dialogue for the purpose of health promotion in asylum seekers*” (Project Plan, Annex 1). The supreme body of the Red Cross, the General Assembly, made a decision in 2005 declaring “*the need of considerable efforts to improve the health issues of asylum seekers*” (Swedish Red Cross 2005, p.1) . The decision was grounded in the daily experiences and observations by Red Cross volunteers and employees all over Sweden. The conclusion was that the right to health is not obvious to asylum seekers in Sweden. This study is focusing on the protection of health for asylum seekers in Sweden on an individual, community, organisational and public policy level. The aim of the study is to explore the accessibility to health care, possible threats, effects of threats and actions to take to increase the protection of health.

In 2005 the Swedish Red Cross responded to a request from the Swedish Government concerning a bill defining asylum seekers’ right to health care including limitations to access (Westerberg 2005). The Red Cross clarified that according to the principles of the Red Cross (1965) and the United Nations Universal Declaration of Human Rights (UN 1948), the bill expressing limitations in access to health care was not in harmony with these basic principles of respect for human dignity and health. Full access to health care is also a prerequisite for integration into and participation in Swedish society.

The project is partly financed by the European Refugee Fund (ERF)<sup>1</sup>. The author of this report is currently employed by the Swedish Red Cross, as the project leader. More results from the study will be presented in the final report to the ERF in December 2008 and through publications in international peer-reviewed journals.

The author met with Associate professor Solvig Ekblad at the Karolinska Institutet for planning of this research. She was at that time finalising a four-year research project “Health promoting introduction” (Ekblad, Johansson Blight et al. 2005). Ekblad and her research group have published several papers within the field of health and migration and health as a Human Right. That group has provided advice on research methods, transcultural and ethical issues and supported the author in designing the study. The author of this thesis has been a member of the research group, which has been a valuable support throughout the research process.

The author is also registered as a Master student at International Maternal and Child Health (IMCH) unit at Uppsala University, where Professor Lars Åke Person has been assistant advisor in working with this report and a Master thesis on the same topic. Both supervisors have highlighted the importance of, not only identifying challenges but to always strive for identifying solutions to promote health. Associate Professor Ekblad emphasizes the need to “*develop a tool kit*” of the results so they become useful and accessible. A tool kit would according to Asher, Hamm et al. (2007) show the significance and the practical meaning of the right to health.

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<sup>1</sup> [http://ec.europa.eu/justice\\_home/funding/refugee/funding\\_refugee\\_en.htm](http://ec.europa.eu/justice_home/funding/refugee/funding_refugee_en.htm)

The “UN’s Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, Paul Hunt, reports (2007b) that Sweden has ratified international treaties recognizing the right to health but in the domestic laws and policies the right to health is less firmly recognized. Sweden has differential treatment of asylum seekers and irregular migrants resulting in limited access to health care for asylum seekers or no access to health care for irregular migrants. This is a matter of discrimination under international Human Rights law. There is a need to integrate the right to health into the domestic policy-making processes. Further, according to the report *“health professionals in Sweden did not always know about, and sometimes acted contrary to, their patients’ Human Rights”*. [...] *“In addition to clinical responsibilities, health professionals have a duty to promote and protect the right to health, as well as other Human Rights”* (Hunt 2007b, p. 2). This report is based on 28 individual interviews with participants from the Swedish Migration Board and the Swedish Red Cross focusing on the protection of health as a Human Right.

## ***Background***

Before continuing, the author would like, inspired by Nina Larsson (2005) who wrote a Master thesis within the field of protection of health *“to ask the reader to keep the diversity”* of asylum seekers *“as a group in mind”* (p.8) because *“Each person has their unique story and their individual needs”* (p. 8) and the same right to protection under the Universal Declaration of Human Rights (UN 1948).

## **Definitions**

Some definitions essential to this report will be made clear below.

### Asylum seekers

*“An asylum seeker is a person who has left their country of origin, has applied for recognition as a refugee in another country, and is awaiting a decision on their application”*(UNHCR 2008a, Basic definitions). In Sweden the decision is made by the Migration Board or Migration Court of Appeal (2007a). In the Declaration of Territorial Asylum from (1967b) the States responsibility of individuals seeking asylum is defined. The Declaration of Territorial Asylum (UN 1967b) recalls the Universal Declaration of Human Rights which states: *“Everyone has the right to leave any country, including his own, and to return to his country”* (UN 1948, article 13,2 ).

### Refugees

The term refugee is often confused with other migrants but according to the Convention relating to the Status of Refugees (1951) and the Protocol Relating to the Status of Refugees (1967a) a refugee is a person who is *“owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence [...], is unable or, owing to such fear, is unwilling to return to it.”*(Convention relating to the Status of Refugees 1951; UN 1966, article 1,2). The protocol from 1967 is a complement to the Convention from 1951 due to new emergencies and refugee situations in the world according to *“Handbook on Procedures and Criteria for Determining Refugee Status “* (UNHCR 1992). Safeguard the rights and well-being of refugees is to ensure that everyone can exercise the right to seek

asylum and find safe refuge in another State (UNHCR 2008b). A person is a refugee from the moment he/she fulfils the criteria set out in the refugee definition (UNHCR 2007).

### Irregular Migrants

According to Human Rights for Irregular Migrants by the Council of Europe Commissioner for Human Rights<sup>1</sup>, irregular migrants are: *“those who are not refugees or asylum seekers and who are in another country without the state’s consent”*. [...] *“From a Human Rights’ perspective, migrants are entitled to protection under international law, regardless of any irregularity under national law”* (Council of Europe: Commissioner for Human Rights 2007, p. 3).

### Health

The definition of health by WHO (1948) used in the International Federation of the Red Cross and Red Crescent (IFRC 2005) as well as in the Alma Ata declaration (WHO 1978, p. 1) is also used in this Master thesis. The definition in combination with the additional text concerned with the Human Rights and social aspects of health from the Alma-Ata declaration is *“health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity”* (WHO 1948; WHO 1978, p. 1), *“is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector”*(WHO 1978, p.1).

### Human Rights

*“The rights people have simply because they are human beings, regardless of their ability, citizenship, ethnicity, gender, language, nationality, race, or sexuality; Human Rights become enforceable when they are codified as conventions, covenants, or treaties, as they become recognized as customary international law, or as they are accepted in national or local law”* (The University of Minnesota Human Rights Center 2008, Glossary of terms).

### Access to health care

Within research about access to health care in the United States Bodenheimer and Grumbach (2005) used the following definition: *“Access to health care is the ability to obtain health services when needed”* (chap.3). Bodenheimer and Grumbach explain that there are two major components of accessibility; first it is the ability to pay and second it *“is the availability of health care personnel and facilities that are close to where people live, accessible by transportation, culturally acceptable, and capable of providing appropriate care in a timely manner and in a language spoken by those who need assistance”*(Bodenheimer and Grumbach 2005, chap.3). This definition has been chosen because it includes all the components of access included in this study.

### Protection

*“The word protection means the act of protecting or the condition of being protected or something that keeps (one) safe”* (English dictionary 2006). According to an official statement by Angelo Gnaedinger, ICRC Director-General *“The essence of protection is captured in the definition now accepted by most agencies including the ICRC: “all efforts*

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<sup>1</sup> “The Commissioner for Human Rights is an independent institution within the Council of Europe, mandated to promote the awareness of and respect for Human Rights in 47 Council of Europe member states”.  
[http://www.coe.int/t/commissioner/Activities/mandate\\_en.asp](http://www.coe.int/t/commissioner/Activities/mandate_en.asp), Retrieved 22 Sept 2008.

*aimed at obtaining full respect for the rights of the individual and of the obligations of the authorities/arms bearers in accordance with the letter and the spirit of the relevant bodies of law” [...]. (ICRC 2007, para. 2).*

### Threat

Can be defined as “An indication of impending danger or harm”(The free dictionary 2000, webpage) . For the purposes of my report I define threat as: any action or omission that endangers the protection of one’s health.

## **Asylum seekers, statistics, health and vulnerabilities**

### Statistics from an European and Global perspective

In 2007, Europe received 254,200 claims from asylum seekers, a 13 per cent increase from 2006. A similar trend was observed among the 27 Member States of the European Union which recorded 222,900 new asylum applications in 2007, 11 per cent more than 2006. This increase comes despite the fact a few traditionally receiving countries recorded the lowest numbers in years or even decades (e.g. Germany, France, and the United Kingdom). During 2007, Greece and Sweden emerged on the top of the list. More than 46,400 new asylum-seekers were registered in the Nordic countries, 12,500 applications or 37 per cent more than during 2006. Sweden lodged 36,200 of these claims, that means every four out of five claims to the Nordic countries. Norway lodged 6530 claims, Denmark 2230 and Finland 1430 asylum claims. The claims to Sweden 2007 were 49 per cent more than 2006 related to many Iraqi asylum applications (UNHCR 2008c). Applying a global perspective it may be mentioned that by the end of 2006 the number of persons of concern for the UNHCR was 32.9 million, including 744,000 asylum-seekers (UNHCR 2007).

### Statistics from Swedish Migration Board

In 2007, the Migration Board received 36 207 asylum applications, among these 1264 (3,5% <sup>1</sup>) unaccompanied children (Migration Board 2008a). The five most common countries of origin for asylum applications were Iraq 18 559 (51%)<sup>2</sup>, Somalia 3349 (9%), Serbia 2500 (7%), Stateless 1382 (4%), and Eritrea 878 (2%). Concluded asylum cases were 32 492, granted cases 15 639, and rejected cases 12 177. People who left the reception system without receiving residence permit were 6035 (Facts & Figures 2007, Migration Board 2008c).

### Asylum seekers, refugees & irregular migrants statistics from Swedish Red Cross

In 2007, approximately 34 000 individuals received advice and support in the asylum process, 2766 family members were reunited, 1207 traumatised and tortured people received medical care and rehabilitation at six different centres, among those 164 children and youth. Consultations provided to irregular migrants that did not have access to the regular health care system were 1050. This was provided through the Red Cross network of physicians, midwives, psychologists and physiotherapists<sup>3</sup>. Over 46 000 people have also participated in the Red Cross education on Human Rights, international humanitarian law and education about the protection for refugees, asylum seekers, displaced people and irregular migrants<sup>4</sup>. Asylum seekers participate in local activities arranged by Red Cross volunteers such as practicing Swedish in conversation groups, introduction to Swedish society, swimming lessons etc. There are also approximately 300 meeting points<sup>5</sup>, places to meet new people,

<sup>1</sup> Calculation by author, result with one decimal.

<sup>2</sup> Per cent concerning nationality, official statistics from the Migration Board, with no decimal

<sup>3</sup> Reception for irregular migrants “Vård för gömda”

<sup>4</sup> In Swedish. “Människor på flykt”

<sup>5</sup> Mötes plats Kupan, 2<sup>nd</sup> hand shops and meeting point

have a coffee in combination with second hand shops for clothes etc. (Swedish Red Cross 2008)

#### Asylum seekers, health and vulnerabilities

Elevated rates of mental illness, particularly post traumatic stress disorder (PTSD) and major depression in post-conflict populations including refugees are well documented, as well as evidence of the relationship between trauma, memory functioning and symptoms of psychological distress (Steel, Frommer et al. 2004b). Results from research also show a significant association between traumatic events, impaired mental health status and decrease of social functioning (Cardozo, Vergara et al. 2000).

The European Academies Science Advisory Council (EASAC 2007) made a statement *“that most migrants to the EU are healthy but in population terms may bear a disproportionate burden of infectious diseases”*(p.1). The public health implications of migration have received comparatively little attention in EU policy development according to EASAC, and comprehensive research based information on the burden of infectious diseases is currently lacking. According to EASAC communicable diseases as HIV/ AIDS infections are more likely to be required before entry to EU and tuberculosis (TB) and other diseases linked to socio-economic vulnerability are more likely post entry.

A growing body of evidence suggests that the asylum seeking process itself is associated with psychological deterioration in addition to the effects of exposure to pre-migration torture and trauma (Steel, Frommer et al. 2004b). Not only mental health is affected by the asylum process itself. According to a recent study from the Netherlands among Iraqi asylum seekers there is a relation between the length of the asylum process and a lower quality of life, more physical complaints and higher functional disability among the asylum seekers (Laban, Komproe et al. 2008). In a study from Australia (Momartin, Steel et al. 2006) it was also found that refugees with temporary protection visas had increased post migration stressors compared to those with permanent protection visas <sup>1</sup>.

The asylum seekers in an explorative study in Finland (Koehn 2006) explain that receiving a permanent residence permit would be the most important improvement for their mental health. The major finding in the study is that the immigration status plays a role in the patients' perception of post migration health outcomes. Koehn (2006) also found that the health outcome is affected by the nurses and physicians cultural experiences such as working with interpreters or being able to talk the first language of the patient.

Many asylum seekers residing in Australian communities who have limited or no access to health, welfare, and social services in combination with the stressors of the asylum seeking process, have been found to have higher occurrence of symptoms of depression and PTSD (Silove, Steel et al. 1998; Silove 1999). Refugee populations are in different ways at risk and have been recognized as having unique and complex health needs, which require attention both upon arrival and throughout the process of resettlement (Harris and Telfer 2001; Grove and Zwi 2006). Among asylum seekers in detention, mental distress is common and just staying in detention is a risk for retraumatization of pre-migration traumas (Steel and Silove 2001). Post migration stress facing asylum seekers adds to the effect of previous trauma in

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<sup>1</sup> In Sweden and EU it is called residence permit, (Ref. Richard Olseke, EU migration and asylum, policy advisor, Swedish Red Cross, personal conversation 16 Sept. 2008.) Information about definition of protection visas in Australia [http://www.immi.gov.au/refugee/seeking\\_protection.htm#protection\\_visa](http://www.immi.gov.au/refugee/seeking_protection.htm#protection_visa), retrieved 19 Sept 2008.

exacerbating risk of ongoing posttraumatic stress disorder and other psychiatric symptoms (Silove, Steel et al. 2000).

It is common that asylum seekers come from regions with war and Human Rights violations. In a systematic investigation of exposure to traumatic events and their psychological impact of a group of 573 asylum seekers, sixty-two percent reported exposure to one or more traumatic events and eighteen per cent had been tortured. Thirty-seven per cent reported at least one severe symptom of ill health, most often of a psychological nature one week after arrival, and persons who reported torture had more symptoms (Loutan, Bollini et al. 1999).

### **Participants' organisations**

In this study participants come from the Swedish Migration Board and the Swedish Red Cross. Their tasks and activities from 2007 in relation to asylum seekers are presented as follows;

#### Swedish Migration Board

The Migration Board (MB) is “*a central administration within migration[...]responsible for ensuring that the whole migration chain functions efficiently*” (Migration Board 2006, p.3). The MB makes decisions about work permits, residence permits, asylum and citizenship and is responsible from the border through to citizenship or repatriation. “*People who seek protection in Sweden do so after they have arrived here. We are then responsible for ensuring that they are received and have somewhere to live while their asylum applications are examined by us and often also by the migration courts*” (Migration Board 2006, p.3).

#### Swedish Red Cross

The Swedish Red Cross is one of 186 national members of The International Federation of Red Cross and Red Crescent societies (IFRC) and the IFRC is: “*the world's largest humanitarian organisation providing assistance without discrimination as to nationality, race, religious beliefs, class or political opinions*”(IFRC 2008). The vision for IFRC is to: “*strive, through voluntary action, for a world of empowered communities, better able to address human suffering and crises with hope, respect for dignity and a concern for equity*” (IFRC 2008). The Swedish Red Cross has 262 616 members and approximately 40 000 of them are involved in volunteer activities(Swedish Red Cross 2008). There is also employed staff at national, regional and local levels.

### **Reception systems for Asylum seekers**

#### Reception systems of asylum seekers in the European Union

In October 1999, EU governments agreed upon establishing a Common European Asylum System during the initial period, Tampere process, 1999 - 2004 and a follow-up period Hague programme, 2005-2010 (Gröschel, Beciragic et al. 2006). The initiative to a common EU asylum and Migration Policy was taken. “The Tampere Milestones” confirms that the freedom should not only be for the European Unions' own citizens' but for many others who can not enjoy their freedom. The Tampere milestones requires common policies on asylum and immigration for the Union (European Parliament 1999).

If an asylum seeker arrives to a country within the European Union and applies for asylum this is the country where the asylum process will start and take place. Asylum seekers will according to the Dublin convention (1997) be sent back to the first country (Council 2003). A directive was given according to the minimum standards of the reception of Asylum seekers in EU. New EU regulation on migration and international protection statistics entered into

force, July 2007. EU member States are required to provide the European Commission (Eurostat) with a set of comparable data; asylum claims, decisions, pending cases, sex and age (UNHCR 2008c) as well as fingerprints data (Commission of the European Communities 2007).

#### Reception system of asylum seekers in Sweden

*“The asylum rules in Sweden are laid down in the Swedish Aliens Act, into which the UN Convention relating to the Statues of Refugees (UNHCR 1951) have been incorporated”* (Migration Board 2007a, p.1). Sweden is required to examine every asylum application according to the Refugee Convention. People who are not refugees but in need of protection can also be granted a residence permit as well as those who have so called “particularly distressing circumstances” who can be granted residence permit based on a collective assessment of the circumstances. Each asylum application is examined individually. In all cases the children’s best interest (Convention of the Rights of the Child) must be specifically taken into account (Migration Board 2007b).

#### Living conditions, school, organised activities and work, in Sweden.

While the Migration Board investigates the case, the asylum seeker can choose accommodation with a relative or friend, independent accommodation, or accommodation provided by the Migration Board. For asylum seekers who do not have money there is a financial assistance with a daily allowance between 24 -71 SEK/ adult to cover all expenses except medical care.

Children and young people who are asylum seekers are not obliged to go to school but the municipality is responsible to offer a place on the same terms as to other children in the municipality. During the time when the asylum seekers between 16-65 years are waiting for a decision they must take part in activities organised by the Migration Board. If the Migration Board estimates the asylum process to be more than 4 months the asylum seeker is allowed to work (Migration Board 2007b).

### **Access to health care for asylum seekers**

#### Health and medical care for asylum seekers in Europe

In 2004, Norredam, Mygind, Krasnik (2006) carried out a comparative study on country policies concerning access to health care for asylum seekers in 25 countries of the European Union (EU). The results showed that EU countries have considerable differences in their health policies. In all countries, except Greece, a medical screening was provided upon asylum seekers arrival. It varied if the screening was voluntary or not, as well as the contents of the screening practice. Legal restrictions in access to health care were found in 10 countries 2004; *Austria, Denmark, Estonia, Finland, Germany, Hungary, Luxembourg, Malta, Spain, and Sweden* (Norredam, Mygind et al. 2006, p. 287). In those countries asylum seekers were only entitled to emergency care. Several of the practical barriers were also identified.

#### Health and medical care for asylum seeking adults in Sweden

Asylum seekers > 18 years have, according to the legal framework in Sweden, right to access emergency care and care that cannot be deferred, emergency dental care and dental care that cannot be deferred,<sup>1</sup> as well as maternal care. All asylum seekers are offered one medical

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<sup>1</sup> “Care that cannot be deferred”, synonym to defer: postpone, wait. This expression is from the law. In Swedish “Vård som inte kan anstå, synonym till anstå; uppskjuta, dröja med något. Source: <http://lexin.nada.kth.se/cgi-bin/sve-eng>

examination free of charge, called the voluntary health control for this Master thesis. In 2007, 45 per cent of the newly arrived asylum seekers participated in the voluntary health control – an increase from the year before, when only 30 per cent were examined (SALAR 2008). Migration Board staff members should give information concerning the asylum seekers' rights and limitations of rights within 15 days from the application of asylum, according to a decree<sup>1</sup> 1994:361 §2 (Justitiedepartementet 1994).

In a hearing arranged by the Swedish Red Cross and a group from the Swedish Parliament (2008), a representative for the National Board of Health and Welfare, Mr Elis Envall said<sup>2</sup>: “*Care that cannot be deferred, we do not know what that means. We think it is a risk that the Human Rights will become violated and we want to do an investigation about [the expression]*” (2008), broadcast).

#### Health and medical care for asylum seeking children in Sweden

A child, < 18 year, who is an asylum seeker is entitled to medical and dental care on the same terms and conditions as other children in Sweden (Migration Board 2007b). In the debate of the legal framework the right of access to services for all children has been clear to all participants. Although, it is important to remember that the majority of children seeking asylum in Sweden have parents who have limited access to health care<sup>3</sup>.

### **The Swedish legal framework for access to health care**

The history of the national legal framework for access to health care for asylum seekers has changed during the time period for this study, but the limitations for asylum seekers has been the same. The legal framework has changed as follows:

- A mutual agreement between the Swedish Association of Local Authorities and Regions (SALAR) and the Swedish parliament from 2006 valid to 30 June 2007, is based on the first agreement from (Swedish Government 1993). In the mutual agreement irregular migrants are not mentioned. The agreement is, according to the author, focusing mainly on who will pay the cost for the care given, the Migration Board or the County Councils.
- The Swedish Government introduced a governmental bill<sup>4</sup> to the Swedish parliament (Swedish Government 2008 b) with the aim of becoming a national law from 1st of July 2008. The bill had the same limitations as the agreement (1993) concerning access for asylum seekers. Limitations for irregular migrants were a new addition. See the text below, the law from 21 May 2008.
- In May 2008 several County Councils made local decisions that irregular migrants will receive care (Carlbom 2008) even though the government was questioning this.
- 21 May 2008 the Swedish Government accepted the limitation of access to asylum seekers as a national law (2008a). Irregular migrants have access if they pay the full cost of the care, but no access if they are avoiding execution of the deportation. [Access to health care] “*is not available for foreigners keeping away from the execution of the [deportation] order, if he or she is 18 years of age*”<sup>5</sup> (Swedish Government 2008a, para. 4).

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<sup>1</sup> In Swedish, förordning

<sup>2</sup> Translated from Swedish by the author

<sup>3</sup> This statement concerning children was given within the interest group to the project, (Annex 1), November 2006.

<sup>4</sup> 2008:2007/08:105 (in Swedish lag proposition)

<sup>5</sup> Translation by author.

## 2. THEORETICAL FRAMEWORK

### *A combination of Human Rights and the health arrow*

The framework for this study is based on two perspectives of health; first perspective is the protection of health based on the Universal Declaration of Human Rights (UN 1948) implemented to several legal instruments on national and international level. The second perspective is a multi level framework. This framework “the health arrow”<sup>1</sup> can be used to categorize factors (Lindencrona 2008) that have positive or negative effects on individual’s health (Lindencrona, Ekblad et al. 2001; 2005). Human Rights is one of the levels in the health arrow.

### **The meaning of Human Rights**

The Universal Declaration of Human Rights (UDHR, UN 1948) is one of the most important international instruments. UDHR has been implemented in several conventions ratified by the majority of states and translated into 335 languages in May 2008. The first article in UDHR, declared three years after the end of the 2nd World war that the responsibility of each one of us is to create a world with peace, justice and freedom. *“All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood”* (UN 1948, article 1). According to associate professor in ethics at Lund’s university, Hans Ingvar Roth (2007) in his book: *“What are Human Rights?”*<sup>2</sup>, there are sometimes disagreements about the meaning and applications of the universal Human Rights. The strength is within the expression of respect for human dignity. It has a central meaning to different religions and philosophic disciplines. Roth describes furthermore that one can not value human dignity by empirical data or analysis; it is a normative expression that refers to normative issues like integrity, autonomy as well as needs and interests of each human being.

### The protection of health as a human right

All Human Rights – including the right to health – apply to all people (UN 1948), that include refugees, migrants, and irregular migrants and other non-nationals<sup>3</sup> (WHO 2003). In a review (Lindencrona, Ekblad et al. 2005) of available literature, evidence is given to the connection between violation against Human Rights and negative consequences for health, especially for individuals exposed to war, refugees and asylum seekers. *“Health is a fundamental human right, which is necessary for the exercise of other Human Rights and freedoms and also essential for poverty reduction. In short, health and Human Rights are complementary and interconnected approaches towards sustainable human development and the advancement of human well-being”* (OHCHR 2002, p.6).

The right to health is usually divided into two categories: components related to health- and medical care and components related to basic conditions such as clean water and food (Tønnes 2006). In UDHR (1948) it is clarified that the right to health is not only access to health care, it is; *“ the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary*

<sup>1</sup> “The health arrow” expression has been used in daily conversations by S.Ekblad, while talking about this multi level framework a *“socio-ecological perspective on refugee mental health”* (Lindencrona 2008 p.20)

<sup>2</sup> Translation from Swedish by the author. Titel in Swedish: *Vad är mänskliga rättigheter?* Roth 2007.

<sup>3</sup> *“Non-national population refers here to persons who are not citizens of the country in which they reside, including persons of unknown citizenship and stateless persons”*. EUROSTAT (2006). Population and social conditions. Statistics in focus, Eurostat. (p.3)

*social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection” (UN 1948, article 25:1,2).*

The right to health is recognised in numerous international instruments with components that are legally enforceable. Health policies, implementation of health programmes or adoption of specific legal instruments are some of the approaches for realising the right to health. (Committee on Economic Social Cultural Rights 2000)<sup>1</sup>.

#### Health and International Human Rights law

The International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966) provides the most comprehensive article on the right to health in international Human Rights law (Committee on Economic Social Cultural Rights 2000). Article 12: 1 describes the right of individuals’ and article 12:2 describes steps to be taken by the States for the realisation of the full right to health (UN 1966)<sup>2</sup>.

The right to health is also recognised in the “International Convention on the Elimination of All Forms of Racial Discrimination of 1965”, “ the Convention on the Elimination of All forms of Discrimination against Women of 1979” , and “ the Convention on the Rights of the Child of 1989” (Committee on Economic Social Cultural Rights 2000).

Several regional Human Rights instruments also recognize the right to health: the Additional Protocol to the American Convention on Human Rights in the Area of Economic, and Social and Cultural Rights of 1988, the African Charter on Human and Peoples' Rights of 1981 and the European Social Charter of 1961 (Committee on Economic Social Cultural Rights 2000).

#### Public health and Human Rights

In the Ottawa charter (WHO 1986) the goal was defined as “*health for all by year 2000*” (p.4) but Human Rights were first time named (Gruskin and Tarantola 2000) in a public health strategy 1987 when WHO (1987) made the first global response to AIDS. A call for Human Rights, solidarity and compassion with people living with HIV/AIDS. The right to health is not an isolated right, if the protection of the right to health is violated, usually several other rights are violated for example article 4 (UN 1948) the protection against cruel, inhuman or degrading treatment or punishment (Gruskin and Tarantola 2000).

### **The health arrow – a multilevel framework**

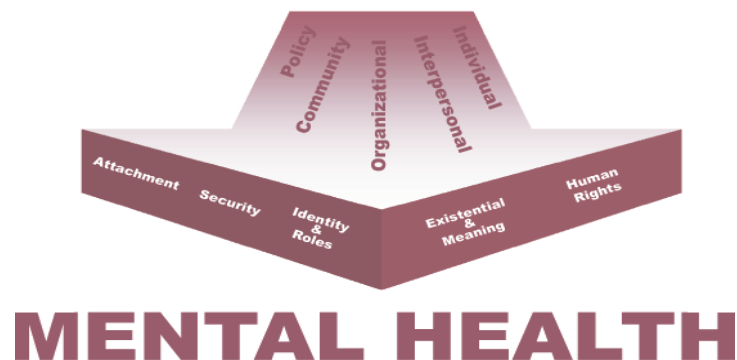
The second part of the framework is a model developed by (Lindencrona, Ekblad et al. 2001; 2002; 2005; Lindencrona 2008). Action on the different levels within the arrow can have negative or positive effect on individual’s health. In the (figure 1) it says mental health, but in the Swedish version (Lindencrona, Ekblad et al. 2005) it is an arrow indicating health. In this report we focus on health. The health arrow is a combination of five important health areas

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<sup>1</sup> The Committee on Economic Social Cultural Rights describes in the general comments how the states will implement and interpret the International Covenant on economic, social and cultural rights (1966).

<sup>2</sup> The whole text of Article 12 is presented here: *Article 12.1. “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” Article 12. 2. “The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness” International Covenant on Economic Social and Cultural Rights (1966). Ratified by Sweden 1976 (<http://www.unhchr.ch/pdf/report.pdf>, retrieved Aug 2008).*

by (Ekblad and Silove 1998; Silove 1999) with five action levels by (McLeroy, Bibeau et al. 1988). The framework is also used by N. Larsson (2005) in her Master thesis.



**Figure 1. The health arrow**

Graphical layout: Gunilla Andersson and Fredrik Lindencrona. Original text: “*Refugee and mental health during resettlement: An integrative framework.*” (Lindencrona 2008, p.21). The figure is published with the authorization by F. Lindencrona.

#### The five health areas and five action levels

According to Silove (1999) torture and other Human Rights violation “*challenge five core adaptive systems*” (p.200) ”The systems are; “*safety,*” “*attachment,*” “*justice,*” “*identity-role,*” and “*existential-meaning*” (Silove 1999, p.200). The safety system explains for example, according to Silove, the negative health effects of threat, during situations of Human Rights violation as well as in posttraumatic environment. The justice system explains the negative effect of individuals’ health with symptoms like anger and depression; this is caused by lack of legal assistance in a chaotic life situation. Lindencrona, Ekblad et al (2005) call the justice system “*justice/Human Rights*” (p.14). The five action levels are “*individual, interpersonal, organisational, community, and public policy- levels*” (McLeroy, Bibeau et al. 1988, p. 351). Representatives from different bodies’ can act on different levels and the activities taken will have effects on the individual’s health.

### **3. AIMS & OBJECTIVES**

#### *Aims*

The aim of this Master project is to explore the protection of health for asylum seekers in Sweden according to article 12.1 and 12.2 in the International Covenant on Economic Social and Cultural Rights (1966) as well as the protection of health within the Swedish national legal framework. The aim is as well to identify possible threats, effects of such threats as well as to explore actions that could be taken to improve the protection of health. The situation will be explored as perceived by staff working with different activities of the Swedish Red Cross with asylum seekers, irregular migrants and refugees, and staff members working at the Swedish Migration Board Asylum reception.

## ***Objectives***

- To identify the presence of threats to the protection of health for asylum seekers in Sweden.
- To explore the protection of health concerning accessibility to health care on an individual, community, organisational and public policy level.
- To explore possible effects of threats to the protection of health.
- To explore actions to take to protect asylum seekers' health.
- To identify areas for future research.

## **4. METHODS**

This is a qualitative exploratory study where we explored the participants' detailed descriptions of their actions and meanings by semi-structured interviews. Qualitative research methods are particularly useful to examine the meanings of individuals' experiences and actions in the context of their social environment (Polgar and Thomas 1995; Polit and Hungler 1999). To understand the mechanisms behind certain phenomena qualitative research has to understand the world from the participants' point of view related to their social context (Dahlgren, Emmelin et al. 2007). Research involving the interpretation of personal meanings is essential for ensuring effective practices of health care delivery and a qualitative design provides "*evidence and theories which enable us better to understand our clients as human beings*" (Polgar and Thomas 1995, p.115).

### ***Sampling procedure & participants***

Sampling was made as a total geographical investigation from the perspective of the Swedish Red Cross (SRC) activities on a regional and local level. All together nine of ten regions participated in the total geographical investigation. During the time of the study no one was employed to work with asylum seekers on Gotland, one of the ten regions. Gotland region was therefore excluded. Twelve Asylum reception units of the Swedish Migration Board were included according to their geographical closeness to the SRC activities and locations for this study. A total of 35 Asylum reception units in Sweden were identified at the Swedish Migration Board homepage (2006). Twelve Asylum reception units were included according to their geographical closeness to the SRC activities and locations for this study. The closeness was measured on a map and the list of units of the Migration Board addresses compared to the addresses of the Red Cross activities. The author interviewed 28 participants from Gällivare located north of the Arctic Circle to Malmö in the south of Sweden. The interviews took place from May 2007 to January 2008.

### **Sampling and recruitment procedure**

The process of selection of interviewees and the recruitment (table 1) was made according to Polgar and Thomas (1995) recommendations to make it "*less confronting*" (p.39). "*Less confronting*" is to invite participants first by an invitation letter and thereafter personal contacts. The heads as well as the participants were informed (Invitation and information letter, Appendix 4A-D) about the aim of the study, the purpose of the interview, and a number of assurances, e.g. maintaining anonymity, ability to vet materials based on interviews before publishing, and the extent of time involved to participate. To decrease the risk of bias in the

sampling procedure for the Swedish Red Cross (SRC) as the author is employed at the SRC, the selection of category of participants was made by a project group and heads of different national and regional departments: a steering group (table 1). The Swedish Red Cross health staff members was chosen by the heads. The author had a few years earlier a professional connection as a co-ordinator for the Swedish Red Cross Centres for Victims of Torture and War but no direct personal contacts with the health staff members for the time of the study, the other category included the Red Cross regional programme officers the author had no professional connections with.

**Table 1. Sampling and recruitment procedure of participants at the Swedish Red Cross and the Swedish Migration Board. Activities in chronological order by the author and participants organisations**

<b>Sampling and recruitment procedure by the author</b>	<b>Red Cross activity</b>	<b>Migration Board activity</b>
1. Personal meeting national heads to present study and to know what category of staff to include in the study	x	X
2. Written invitation to 10 Regional heads, 5 heads for Centres for Victims of Torture and War /1 Reception unit irregular migrants (Invitation and information letters to heads, Appendix 4A)	x	
3. Written invitation to 12 heads of Asylum reception units (Invitation and information letter to heads, Appendix 4B)		X
4. Personal conversation with regional heads, Centres for Victims of Torture and War, Reception unit irregular migrants, possibility to ask questions concerning study	x	X
5. Heads of: Regions, Centres for Victims of Torture and War, Reception units indicate to the author one staff to contact for invitation as participant	x	X
6. Invitation letter to participants (Appendix 4C, 4D)	x	X
7. Personal conversation with participant about acceptance/no acceptance of invitation to participate in the study, possibility to ask questions concerning study	x	X

#### Sampling at a regional level at the Swedish Red Cross

Each regional head of the Swedish Red Cross region and Centres for Victims of Torture<sup>1</sup> and War were all contacted as described in (table 1). The author asked for a verbal permission and directions how to invite one staff with responsibilities to support asylum seekers as a professional or volunteer according to the requirements given by the national heads and explained in the invitation letter (Appendix 4A-D). The heads suggested who to invite and had the possibility to ask questions concerning the study. One participant per region/ Centres for Victims of Torture and War /Reception unit for irregular migrants to participate was included.

#### Red Cross regional programme officers for refugee services

A total of 13 staff members was employed in the nine Swedish Red Cross regions<sup>2</sup>. Nine regional programme officers' refugee services, one per region, received an invitation and were included. Eight Regional programme officers confirmed and participated; one denied

<sup>1</sup> The Swedish Red Cross Centres for Victims of Torture and War are the name of the centres. When the author writes about patients exposed to torture the expression "torture survivor" is used to illuminate the possibility and capacity of human kind to survive cruel and inhuman treatment.

<sup>2</sup> Source; Swedish Red Cross Intranet, address list for Staff, January 2007.

participation. The non-participating regional programme officer referred the invitation to a volunteer within the region. One of the eight participants answered that the region was geographically so large that to give a perspective of the situation would be necessary to include a local volunteer to give a regional perspective of the current situation. The same regional participant said that it was the volunteers in the region who had the main responsibility for each single case of asylum seeker. The two volunteers mentioned above were included.

### Red Cross volunteers

During 2007, twenty-one volunteer groups were involved in the Swedish Red Cross activities with support to asylum seekers, family unification and tracing<sup>1</sup>. Two volunteers from different regions were invited and included. The volunteers had local responsibility to give support in the asylum process, reunification and tracing and they were supervised by the regional officers.

### Red Cross health staff

Five out of six Swedish Red Cross Centres for Victims of Torture and War participated. One of the six centres was excluded because the centre is located in a region with two centres and has the same director. The only functioning Reception for irregular migrant was included<sup>2</sup>. Among the Swedish Red Cross health staff members, five respondents from five different Swedish Red Cross centres for Victims of Torture and war (SRCC), and one respondent for the Reception for irregular migrants were invited, and all six participated in the study. A total of 40 staff members were employed at the SRCC<sup>3</sup> and two staff at the reception for irregular migrants<sup>4</sup> at the time of interviewing.

### Sampling procedure for participants from the Swedish Migration Board

In order to select participants from the Swedish Migration Board a director at a national level of the Migration Board Asylum reception was consulted and suggested that staff members at Asylum reception Units should be invited. It was suggested to focus on staff members working with the reception for asylum seekers who live in independent accommodation and, in addition, a few working with the reception for asylum seekers living in apartments rented by the Migration Board units. The sampling and recruitment procedure is shown in (table 1). As a second step the project was presented for the national director and deputy director at the Migration Board department for Asylum reception (In Swedish: "Staben") and received approval to continue with the invitation to the different units in Sweden. The national and deputy directors gave information to the directors of each unit of the approval to proceed with the invitations, first to directors of each unit and then to one participant per unit.

### Sampling of Migration Board participants

The heads of the 12 units selected one participant according to the requested criteria in the Invitation and information letter (Appendix 4B). In a few cases the selected participant did not fit the criteria. The author spoke to the head again and received a new contact to a participant. At the Migration Board a total of 598 staff were employed at the Asylum reception units in

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<sup>1</sup> Source; informal statistics from national coordinator for reunification and tracing activities, at Swedish Red Cross headquarter. Statistics available in intranet database for Red Cross employed and volunteers.

<sup>2</sup> 2008 there are two Reception Units for irregular Migrants in the Swedish Red Cross regime, but at the time of the study there where only one reception. Source: Annual Report (Årsrapport 2007) Vård för papperslösa, Röda Korset, [papperslos@redcross.se](mailto:papperslos@redcross.se)

<sup>3</sup> Source; oral information 3<sup>rd</sup> April 2007, from the National coordinator for Swedish Red Cross Centres for Victims of Torture and War, staff employed 2007.

<sup>4</sup> Information given to the author during the visit for the interview.

March 2008<sup>1</sup>. Twelve Asylum reception staff members were invited and all participated in the study.

## Participants

The age of the 28 participants ranged from 31 – 75 years with a median of 44.5 years. For information about participants' gender and employer see (table 2), and for participants age see (table 3).

**Table 2.**  
**Participants' gender & employer**

Participants and employer	Male (n)	Female (n)	Total (n)
Migration Board staff	3	9	12
Swedish Red Cross Staff & Volunteers	3	7	10
Swedish Red Cross Health Staff	2	4	6
<b>Total in study</b>	<b>8</b>	<b>20</b>	<b>28</b>

**Table 3.**  
**The age of participants**

Participants and employer	Range (years)	Median (years)	Participants (n)
Migration Board staff	31-65	48	12
Swedish Red Cross Staff & Volunteers	31-75	47.5	10
Swedish Red Cross Health Staff	35 -68	56.5	6
<b>Total</b>	<b>31-75</b>	<b>44.5</b>	<b>28</b>

### Participants area of employment

The Swedish Red Cross participants in the study had the following working positions: Eight staff members worked as regional programme officers, refugee services. Six staff members worked as health personnel at the Swedish Red Cross Centres for Victims of Torture and War or the Reception unit for irregular migrants. Two participants were volunteers, involved in the services to refugees, asylum seekers, tracing and family reunification. The Migration Board participants in the study all worked with the reception of asylum seekers but they had different jobs: Four staff members worked with reception for asylum seekers living in apartments rented by the Migration Board units. One staff member worked part-time with asylum seekers' organised activities, and part-time with asylum seekers living in independent accommodations. Five staff members worked with reception for asylum seekers living in independent accommodation. Two staff members worked both with asylum seekers living in independent accommodation and apartments rented by the Migration Board.

## Ethical considerations

This study was approved by the regional board of Vetting the ethics of research involving humans in Stockholm<sup>2</sup>, May 2007 (record number 2007/206-31). In the preparation of the

<sup>1</sup> Source: Asylum reception Units at the Migration Board according to oral information given to Master student in March 2008 from Clas Lind, Senior Advisor Staff (Staben).

<sup>2</sup> <http://www.epn.se/start/startpage.aspx> access date 15 September 2008

design of this study the supervisors read and approved the project plan. Seven ethical aspects were taken into consideration (Emanuel, Wendler et al. 2000). The ethical procedures and considerations are shown in the right column of (table 4). The middle and left column (table 4) are the requirements and the explanations according to the model of ethical analysis by Emmanuel, Wendler et al. (2000).

**Table 4.**  
**Ethical analysis of the study design and methods used in relation to seven ethical requirements**

<b>Requirement according to (Emanuel, Wendler et al. 2000)</b>	<b>Explanation according to (Emanuel, Wendler et al. 2000)</b>	<b>Procedures and considerations in the current study (M.Stålgren)</b>
Social and scientific value	Intervention that will increase knowledge	Promote health for asylum seekers
Scientific validity	Use of accepted scientific principles and methods	Explorative study by analysing transcribed interviews principles by not using fraud and plagiarism
Fair subject selection	Selection of subjects so stigmatised and vulnerable people are not targeted to risky research and the rich and social powerful not favored for potentially beneficial research	Total geographical investigation where each director for Red Cross region, Migration Board director made the selection of one member of the staff
Favourable risk benefit ratio	Minimising of the risks: Risks to the subject are proportionate to the society	Minimised risk to participate in the inter views for participants (subjects) because of option to enroll. Choice made to not interview asylum seekers because of the risk to do harm
Independent review	Review of the design, proposed subject selection etc	Review was done by supervisors. Review approved by regional board of Vetting the ethics of research involving humans, in Stockholm, record number 2007/206-31.
Informed consent	Provision of information to subjects about purpose of the study procedures benefits, potential risks so that the individual understands the information and can make a voluntary decision to participate or to enroll during interview.	Oral and written information See appendix 4A-D. (Information and invitation letter). Informed consent by participants orally and written
Respect for potential and enrolled subjects	Respects for subjects autonomy & welfare  1. By permitting with drawl  2. Protecting privacy through confidentially    3 Informing subjects of newly discovered risks and benefits 4. Information to subjects about results of research  5. Maintaining welfare to subjects	Procedures to protect participants autonomy & welfare. 1. See appendix 4A-D. for information and invitation to participants 2. Materials are kept only available to the author. Supervisors can read transcriptions but does not know identity of participant. One participant who vet the results material according to Appendix 4C and 4D wanted to delete one sentence in one citation to protect identity and privacy of the participant. The sentence was taken away by the author. 3. Not relevant  4. Will be shown to participants before the public See appendix 4A-D (Information and invitation). 5. Researcher asking during interview if participants want to continue? If questions were relevant? Using laddered question interview technique (Price 2000). Before showing the digital recorder having participants' confirmation that recording interview was acceptable to them.

## ***Data collection***

### **Pilot study**

Six individual semi-structured (both open-ended and closed ended questions) interviews were done in a pilot study to evaluate and revise the interview guide as well as for the author to gain experience with the interview situation. During the pilot study the interview guide underwent some revisions. One of the interviews was made with the main supervisor as an observer. The observer was not told the name of the participant to protect the anonymity of the participant.

Participants from all the different categories in the study participated in the pilot study. Participants were selected through personal contacts of the author or her colleagues at the Swedish Red Cross.

### **Semi-structured interview guide**

The semi-structured interview guide (Appendix 5 A) was evaluated during the pilot study by enabling participants to comment upon issues, make corrections, and provide additional information of value after the interview. Directly after each interview the author made field notes of the interview situation. The interview guide and the field notes were discussed with the main supervisor and in the research group. Field notes is a part of the research process in qualitative research method and can provide possibilities for the interpretation of the interview or observational data gathered (Dahlgren, Emmelin et al. 2007).

During the study the interview guide was revised five times according to what was being learned during the process of data collection according to Polit and Hungler (1999). The following questions from the interview guide are included in the analyses of data presented in this report and translated to English by the author:

- How is the access to health care for asylum seekers in your region, give examples?
- How do you interpret “care that cannot be deferred”<sup>1</sup>?
- United Nation has a Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, Mr. Paul Hunt. He comments in his report concerning Sweden (Hunt 2007b) that health care educations in Sweden do not provide education in Human Rights (HR) and the applications of HR: what is it like for you? As part of your education, did you receive teaching on Human Rights?
- What (professional) support do you get for your work? Supervision? Education?

The following considerations were taken into account in the design of the interview guide and the interview technique: the aspect of follow-up answers or probing open ended to provide a chance to expand on or clarify what had been said (Dahlgren, Emmelin et al. 2007). The use of probing questions according to Price (2002) is a part of the interview as well as a technique. Price (2002) explains the value of probing questions to provide richer data than other ad hoc approaches. He also gives guidance on how to use the technique he calls laddered question technique. The success of interviews when using laddered question technique is that researcher can work ethically and understand the participants’ needs during interview, even though the researcher has little experience of performing interviews. Laddered questions are conceived as operating at one of three levels, less invasive is questions about

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<sup>1</sup> Concept from the legal framework defining the limited access to medical care for asylum seekers and others

actions, then comes knowledge questions and the most sensitive and invasive questions are philosophy related questions those concerned with feelings, values and beliefs. The researcher must be sensitive to use one of the three levels of the laddered probing questions, to start with the first level of action related questions and only proceed to the knowledge and finally philosophy related probing questions if participants give positive response (Price 2002).

The probing questions used after open ended questions to give richer data in this study were according to the laddered question technique (Price 2002);

- What happens, explain? (action)
- What do you do, give an example? (knowledge)
- What do you think? (philosophy)

### **The interviews**

Twenty-eight semi-structured individual face-to-face interviews were carried out during May 2007 until January 2008. The interviews took place in respondents' offices', that in the majority of occasions provided optimal conditions for relaxed interviews. On a few occasions there were distracting noises that disturbed the participants and Master student. The participants were informed that the interview would last 30-60 minutes (Invitation letter appendix 4C, 4D). The interviews lasted anywhere from 35 minutes to as much as 1 hour and 20 minutes.

The interviews were audio recorded with a digital dictaphone, transcribed and analysed. Transcriptions made it possible in the study to make comparative analysis and quotations as illustrations of various points. Audio record interviews can be intrusive for the participants and there is a potential greater rates of refusal to participate (Polgar and Thomas 1995). None of the participants refused to record the interview in this study. Field notes were written immediately after each interview.

All interviews except two were audio recorded. In these two cases only half of the interviews were recorded on account of circumstances not within the authors control. There was a very short time available for the participant and the author to do the interview. Conducting an interview under stress is not preferable due to the fact that stress from the interviewer transmits quickly to the participant (Dahlgren, Emmelin et al. 2007). To solve the situation in the best possible way the decision was made to ask the participant for a solution that could be suitable. Both participants wanted to proceed and decided to do as much of the interview as possible during the time that was left. One of the participants preferred to complete the interview with written answers to the questions that were left. The other participant preferred to continue by a phone interview another day. Both interviews were completed by the different method suggested by the participants.

### ***Analysis of data***

In this qualitative explorative study the findings from individual interviews with twenty-eight participants from the Swedish Red Cross and the Swedish Migration Board involved with asylum seekers different health aspects of life were transcribed with qualitative conventional content analysis (Hsieh and Shannon 2005) with supervision from main supervisor and a member of the research group, as described in the analysis using conventional content analysis (Shahnavaz and Ekblad 2007).

### The analytical process

- The textual data, transcripts and field notes, were transcribed by the author and then read several times to obtain a better understanding of the material as a whole.
- The citations as a whole were manually organized with the Microsoft Word and Excel programme according to the questions in the interview guide.
- Data were then read word by word, and the text material was organised according to the topics in the text (topic coding), first by highlighting the exact words from the text and later by code labels that came from interpretation of and reflection on meaning (analytical coding).
- Reflections and ideas were saved in notes and memos during these processes.
- Finally the citations were organized again manually according to the identified themes and patterns.

Qualitative content analysis is defined “*as a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns*” (Hsieh and Shannon 2005, p.1278). Conventional content analysis is used with a study design aiming to describe a phenomenon, when existing theory or research literature is limited. In conventional content analysis coding process, the researchers allow the categories and names for categories to flow from the data and avoid using preconceived categories (Hsieh and Shannon 2005).

### Scientific rigour

Validity and reliability checks are neither possible nor always desirable in qualitative studies in the way they are in quantitative studies (Richards 2005). However, some measures that can enhance the data’s credibility were by the following actions: The research process analysis was discussed in a multidisciplinary research group Migration and Health (in transcultural psychiatry/psychology supervised by the main supervisor). The results of the study have been shown to participants before publication, to vet and to comment the material based on the interviews.

## **5. RESULTS**

### ***Introduction***

In the results, two main themes were identified; the first main theme is Threats to the protection of health for asylum seekers in Sweden. Six threats were identified, each threat has three sub headings: threats to protection of health, identified effects of threat and explored action to take. One of the threats has sub themes linked to the threat. An overview of threats with sub themes can be seen in (table 5). Regarding the second main theme of the results, Staff needs of support to protect health, there are two identified needs of improvements: Participants’ education in Human Rights and their supervision (table 6). Participants’ explored answers are presented as sub themes.

**Table 5. Result overview first main theme of results: Six identified threats to protection of health for asylum seekers in Sweden, with sub themes identified effects of threats, and explored action to take.**

Identified threats to protection of health for asylum seekers in Sweden, (no hierarchical ranking)		
Threats	Identified Effects of threats	Explored action to take
First threat: The legal framework	x	x
Second threat: Assessment of health care needs	x	x
Third threat: Financial aspects of health care	x	x
Fourth threat: Geographical disparities of health care delivery	x	x
Fifth threat: Gatekeepers and care access	x	x
Sixth threat: Availability of access to health care	x	x
<i>Sub theme:</i>		
<i>Information &amp; information routines,</i>	x	x
<i>Technical, linguistic and cultural issues</i>	x	x

**Table 6. Result overview second main theme: Staff needs of support to protect health. Two identified needs; Education in Human Rights and Supervision, with sub themes of explored answers**

Staff needs of support to protect health	
Support to participants	Exploration of answers
Education in Human Rights	Swedish Migration Board participants' education in Human Rights
	Swedish Red Cross participants' education in Human Rights
Supervision	Swedish Migration Board staff having supervision
	Swedish Migration Board staff not having supervision
	Swedish Red Cross participants having supervision
	Swedish Red Cross participants not having supervision

### *Identified threats to protection of health for asylum seekers in Sweden*

Six identified threats not in any order of importance are identified as the first main theme of results (Table 5).

#### **First threat: The legal framework**

##### Threats to the protection of health

All participants from the Migration Board answer that they give information concerning the asylum seekers' rights. The information given about the available access to health care is limited to emergency care and "care that cannot be deferred"<sup>1</sup>, for asylum seekers 18 years

<sup>1</sup> "Care that cannot be deferred" is one phrase from the legal framework defining the entitlement to medical care for asylum seekers and "others" (others means migrants, authors comment).

and over. Asylum seeking adults as well as children, under 18 years also have the right to a voluntary health control. The right to health care for asylum seeking children until 18 years of age is an equal right as for children living as Swedish citizens, a right with no limitations, but several examples with limitations to access for children are explored in the study.

#### Effects of threats related to the legal framework

Asylum seekers usually ask about the meaning of care that cannot be deferred? One respondent from Migration Board exemplifies:

*” But, when I have my information meeting I always say... you will receive care that cannot wait. Eh, and then, they have a weird look and they do not really understand what I say.”*

All twenty-eight participants in the study answered the question “how do you interpret care that cannot be deferred”? The majority answered that it is difficult to interpret or understand and some participants both from the Migration Board and the Swedish Red Cross said they can not answer because they do not know. A few said it is the physician’s responsibility but the medical doctors and dentists have difficulties with the interpretation too. Several of Migration Board’s staff members explain that medical doctors and dentists call the Migration Board and ask about what is included in the expression “emergency care” and “care that cannot be deferred”. Migration Board staff members answer that if anyone would know it would be the physician, it is not the Migration Board staffs’ responsibility.

The Swedish Red Cross programme officers and health staff members’ highlights that it seems to be a discretion of the interpretation of the law. Several of the Migration Board staff members mention that the way they should interpret the legal framework is not as they prefer to interpret it or how they interpret it for their personal health or their own children. Another explanation is that laws are supposed to be followed but staff members have to use their common sense. The following citation from a participant of the Migration Board staff members exemplifies the reasoning:

*“Well, really, if I interpret it as we should, that is that you will die if you do not get care, or you will get so seriously ill that you can not gain your health in a very long time period. Oh, it is such a miserable concept, really. If someone experiences them self as ill and someone says to that person, no, this is nothing. Take two aspirins and go to bed for a while. I mean that person will for sure become more ill.”*

Answers differ between participants with medical education and those without it. The Swedish Red Cross health staff answer that it means emergency care, but raised questions to what is “care that could not be deferred”? They say that it is important to see the asylum seeking patient’s well being both mentally and physically with a wider perspective. The following example from a Red Cross health staff member citation exemplifies:

*“I thought a lot about human values, if it is my interpretation of it, it doesn’t have to do only with life saving activities but also I think probably in this way about humanity, how you think, you must think... [...] what the situation of the human being looks like, how she is both physically and psychologically. Consequently you have to put quite wide human conceptions into this, according to my opinion.”*

Migration Board staff members and Red Cross regional programme officers and volunteers without medical training try to make different suggestions that it might be heart attacks, appendicitis, broken arm/leg and accidents, things that if not treated will cause very severe suffering or death. Some other examples of diagnosis that if not treated might be care that cannot be deferred are for example a wound and loss of sight. This citation exemplifies one way of dealing with the issue as a non-medical trained participant from the Migration Board; this staff also mentions HIV-positive asylum seekers need for treatment:

*“...for example, if you do not do this heart valve surgery or enters (surgically) and does this, then, pacemaker or other things, then the person dies, for example. [...]. It could be special... with HIV and those things, with anti-viral medicines and similar of that sort, as long as they are in Sweden they could need that care. It answers it self on that question, to make that person functioning. It could be an eye that is not very well and that you might lose the sight, if you do not have a surgery. [...] If you only should have the emergency conception, well, that is important then. If you do that surgery you might save the sight. Maybe you could have 70 % sight on that eye instead of losing the sight.[...] It has to function in the future, either in Sweden or in the home country. So, you should not make people become cripples, if you can prevent it. “*

Red Cross regional programme officers describe asylum seeking teenagers as a group with a complicated and fragile life situation. All children have their right to access to health care but according to participants from both groups in reality the access is not equal as for children with Swedish citizenship. When asylum seeking children become > 18 years their access to health care become limited according to the legislation.

#### Explored actions to take concerning the legal framework

To protect health, the majority of Migration Board staff members and all Red Cross staff members say it would be better to have a more generous interpretation of what is “care that cannot be deferred”. Participants also comment that it is an imprecise expression. Even medical doctors and dentists who have the responsibility to interpret it have difficulties in doing so.

The majority of Red Cross regional Programme Officers say that the access to health care should be entitled without discrimination, based on the need of medical care and not on patient’s legal status.

Swedish Red Cross health staff members says that it is important to see the patients well being both physiological and psychological in a much wider perspective, only life saving efforts is not a satisfactory interpretation. Migration Board staff members also mention that it should be indicated what is included in “care that cannot be deferred”. Red Cross health staff, regional programme officers as well as volunteers explain that the need of care for the psychological status of asylum seeker should be included into care that cannot be deferred.

Gender perspectives of “care that cannot be deferred” are the following according to a few Migration Board staff members: All care that has to do with women’s special needs of health care should be considered as care that cannot be deferred. Men, on the other hand do not have the same special access to health care as pregnant women and children. Asylum seeking men are having the most difficulty accessing health care.

Both groups of participants have given a few answers that asylum seekers want to work, to have a life and to integrate into the society, that asylum seekers just like everyone else does not want to have an appointment with the physician if there is no reason for that. One of the Migration Board staff member describes that we all have something to gain if everyone in the country could have equal access to health care. Some Red Cross regional programme officers highlight the right to health care as a human right and their hope that the Red Cross as an organization can work for this right to access. Here follows a Red Cross health staff description about the human value issue:

*“... But otherwise, these things that would be needed for the quality of life not to get worse, that is very unnecessary, that this, this costs more than in another end anyway. [...] Many experience that the worst time in all of this is this time you know. Also the refusal of entry [to health care] that is to say, because it has to do with the human value, the recognition of human dignity. And this also affects your health as a whole. The feeling that nobody cares etc. It has so many affects if you can receive help, more help concerning health and medical care.”*

### **Second threat: Assessment of health care needs**

#### Threats to the protection of health

Both Migration Board and Red Cross participants highlight the situation for asylum seekers just because they came to Sweden, that their health care needs can be assessed as care that can defer but in other countries it could have been different. Migration Board staff members often explain that it is not their obligation, professional duty nor are they qualified to do the assessment of an asylum seeker's health status, it is the medical doctor. A dominant answer from both Migration Board Staff and Swedish Red Cross staff highlights the value of the individual and subjective assessment for each person's own life, for the asylum seeker as for everyone else concerning their own health. One Swedish Red Cross health care staff explains the course of events concerning subjective assessment as follows:

*" [...] Care that cannot be deferred", if I understand the word right, that it can not wait. The patient and I can have one opinion but the doctor could think, well it is no hurry, no panic, then you do not know whose opinion is valid. But as a matter of fact, it should be the patient who decides, as it is for ordinary people who seeks health care [... ]. Asylum seekers because of their unsafe situation and their worries and everything [...] they can not wait, as I can, wait and see.”*

Asylum seekers show Migration Board staff members different symptoms that vary between shellfire injuries and dental problems to receive an assessment of what to do. Several of Migration Board staff explains to the asylum seeker that it is not their duty or profession to take part in the health care system. They refer, as their obligations say, all asylum seekers to the Voluntary health control. Migration Board staff expects all assessments concerning health issues for the asylum seekers been taken care of by health staff members, but a few mention that there is a gap between what they think is care that asylum seekers need and what they receive.

Both groups of participants have experienced that when it is an asylum seeker with need of acute level of emergency care, care is given. A few examples are explored in this study of participants' experience of asylum seekers/patients telling them that they have been refused access to emergency care. Several of the participants have experienced that after emergency care no follow-up care is delivered.

A few participants have described the threat to asylum seekers dignity and health due to uncertain or ignored responsibility or a failure to take actions about assessments. A Migration Board staff citation describes one occasion:

*”There was a man who had a bad liver according to the information from Transit. He came yesterday from the city X, today he had an appointment with a doctor in the city X at 9.45, but they put him on the bus. But he was in really bad shape. I said, I’ll take him to the primary health care centre, there is nothing to discuss. There are a lot of discussions like this ”this is not my responsibility”, all the time. [...] But he was taken to the primary health care centre and I called and told them this person was coming and the nurse said: [...] I am busy. But then somebody else has to look at him because this is urgent, I said. Not even an hour later the nurse calls me and tells me that this man is actually dying. And he is taken to the big hospital. And this upsets me profoundly that they are sending such a sick man on a bus from X without even caring that he actually had a doctor’s appointment the same day. I think that is shocking, I don’t think it is humane. And I absolutely don’t think it is worthy a public authority [the Migration Board] to treat people like that. Now I have talked to my boss, now do something about this, we cannot treat people like this.”*

A majority of the Migration Board staff members highlight dental problems as sever and common problems among the asylum seekers. Migration Board staff members also say that some dental sufferings are not considered by dentists as included in the need of emergency care, and that both dental and health problems are assessed differently at different medical care centres. This staff citation exemplifies the suffering and a common situation for asylum seekers:

*“...frequently it is the dental care, maybe it is only two teeth left in the front and there is a need of denture. That is not assessed as an emergency care. And accordingly to the law it might not be emergency care but you need teeth to be able to chew, to eat proper food, not only liquid food, that is important, but you do not receive that [dental care]. That is a conception that the medical care makes the interpretation. The word emergency, it is different assessments at different health care centres. Some health care centres says it is an emergency, others not.”*

Several of the Red Cross regional programme officers do not often deal with health issues. If an asylum seeker tells them about a medical problem, a request of need of help they use their contacts within the Red Cross or other collaborating net works to give support to the issue.

#### Effects of threats related to the assessment of the medical need

Swedish Red Cross health staff members give several examples of medical doctors who have denied patients care by referring to the legal status of the patient instead of medical diagnosis. A Red Cross health care staff gave the following answer:

*“I read a medical record from a patient that had been asylum seeking. The patient had cataract. The patient was nearly blind on both eyes. In the medical record it was written; “we can not perform the surgery because the patient is an asylum seeker, it has to wait until the patient receives permanent protection visa”. And then I mean, if not blindness, nearly blindness is reason enough to care that cannot be deferred, really I think generally the interpretation is done incredibly stiff.”*

Asylum seekers who are torture survivors or war traumatised, the assessment of their need of health care access is made by the legal status. One Red Cross health staff, who receives those patients referred from the County councils Asylum care unit, explains:

*“For example those who have injuries from torture and war, they do not receive care. And they are informed about that they do not receive care for there problems if it is not life threatening. [...] I think it is an important error, really. Because there are those who have really, such incredible problems and to just go and wait to receive four numbers [Swedish citizen id number], as they say. That is sort of the key to receive help.”*

There are different assessments concerning the choice of anti-viral treatment for HIV-infection according to participants' experiences. Following citation from Red Cross regional programme officer exemplifies the effects of different assessment between County Councils in Sweden according to HIV infection and health care for the HIV-positive asylum seekers. *“...You can see different assessments, situations like that where I have had several cases, is how you look at an HIV-infection. Different county councils look differently upon this. Accordingly, if you have HIV, no, it is no diseases in its own, but if you have a virus infection and it could be a need of treatment I have experienced that county councils sometimes make different assessment if you should begin a treatment or not...”*

One example is an asylum seeker with AIDS that did not receive treatment in Sweden nor after denied asylum application and returned to his/her home country. A Migration Board staff helped the asylum seeker personally with financial support so the asylum seeker could come to his family to receive family support until hi/she died. Migration Board staff say that there is lack of financial support to return persons safely to the home country<sup>1</sup>.

Another example of an effect related to the assessment of what kind of care that is needed is, a Swedish Red Cross health staff experienced with a patient suffering of breast cancer. Care that could not be deferred was assessed at the County Council hospital to be surgery of the breast, with no follow up treatment. This patient was a young woman with small children who had to arrange her own treatment for several years afterwards. Concerning surgeries, several of the Migration Board and a few of the Swedish Red Cross participants highlight that surgeries for old injuries is not included in the care that asylum seekers have the right to receive. Swedish Red Cross health staffs highlight the health situation fails on many occasions and the health status of patients become more and more severe when surgery for old injuries is neglected.

If asylum seekers are suicidal, Migration Board staff and Swedish Red Cross staff support asylum seekers to get in contact with emergency care. This care is always given but after this, there is only pharmaceutical treatment available. Swedish Red Cross regional programme officers and volunteers have met asylum seekers who are mentally ill, loaded with big bags full of prescribed psychoactive drugs as the only available treatment.

A few from the two groups of participants mentioned that the asylum process in some cases is affected by the impaired health status. A medical certificate might have importance to the asylum application process and the decision if asylum will be granted.

A few of the Red Cross health staff members and regional programme officers have experienced that their patients/asylum seeker have been denied in-patient hospital care. Here

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<sup>1</sup> Financial repatriation support is available [www.migrationsverket.se](http://www.migrationsverket.se), 217 805 Faktablad om frivillig återvandring. Engelsk översättning. Produktion: Informationsenheten i Norrköping.

are two examples; one patient with appendicitis was not treated with surgery but with antibiotics intra venous at hospital and then referred home with antibiotic tablets and no follow-up. Another situation was a pregnant woman, an irregular migrant who was denied to give birth to her child.

#### Explored actions to take concerning assessment of the need for medical care

Swedish Red Cross staffs highlight that the medical doctors should not, and do not have to assess the patient's need of health care based on legal status. It is also important that medical doctors at medical centres for asylum seekers do refer patients to specialists when needed. Both groups of participants refer to conversations with medical staff about the assessments of health status whether emergency or not and some participants answer that physicians say that they give the treatment due to humanitarian reasons. One answer from the Migration Board staff is that the County council is responsible for health care delivery.

According to both Migration Board and Red Cross participants it is important to receive the asylum seekers and not refuse them, so they at least have someone to talk to when they have a need to talk. They can at least feel that their needs has been recognised and confirmed.

Children's needs are taken care of in collaborating networks in some regions in Sweden. The collaboration networks have participants from Migration Board staff, County Council staff from the Psychiatry, Child and Youth psychiatry department (in Swedish BUP) and the school. In some regions they are focusing on individuals' needs and situations in the networks. They discuss individual children's health issues with the informed consent of the parents to make assessments and decisions about what are the best actions to meet the needs of the children.

Collaborating networks between Migration Board staff, County Council staff from the Psychiatry, Child and Youth psychiatry department and at some places the Swedish Red Cross is included by different collaboration arrangements. Here are the situations concerning asylum-seeking adults generally discussed and by a greater understanding of the situation among the participants from the different bodies' their possibilities to collaborate increases access to health care and organisation of activities linked to rights and well-being like housing, work and school.

Migration Board staff members encourage asylum seekers that have been denied access to health or dental care, to go to alternative dentists or medical doctors to see if their health problems can be assessed differently, in the case of "care that cannot be deferred".

Those Swedish Red Cross regional programme officers or Red Cross volunteers, who are familiar with the health care delivery supply or support in their region contact staff at health care centres, try to support the asylum seekers to receive medical care. A few staff expressed that they need more information of where to refer asylum seekers in their region. A nurse that could screen health concerns is also requested from Red Cross participants. Moreover, a Red Cross staff exemplifies action to be taken by telling about the pregnant woman, mentioned above, who was denied access to give birth to her child at the hospital. The Red Cross regional programme officers solved the situation like it shown in the following citation:

*"Well, that women received help in city X. It turned out well, but we had to use all our contacts, to enable a solution. It was good. In addition, I lack in my region, concerning*

*irregular migrants, as we often meet those who are in need. Moreover, we should probably talk about this at the [Swedish Red Cross International Law and] Refuge Department.”*

Furthermore Red Cross regional programme officers in regions with Red Cross Centres for Victims of Torture and Wars for tortured victims explain that they have no fear to ask asylum seekers if they have experienced severe traumas, because the staff know where they can refer the asylum seeker who shows signals of bad health. A few staff members explain that with no medical care unit to refer to, it is difficult to ask questions concerning ill health and suffering from severe war trauma or torture. One participant explained that after a unit to refer to had opened it changed staff's behavior on how they dealt with asylum seekers who are in need of a medical consultation, concerning severe trauma.

### **Third threat: Financial aspects of health care**

#### Threats concerning financial aspects of access to health care

A dominant aspect concerning access to health care for asylum seekers for both Migration Board and Swedish Red Cross staff members has been a reasoning concerning health and the effects of the limited access to health care in financial terms. Some of the Migration Board staff members say that they would not call into question the decision of a medical doctor to give a treatment when there is a need for financial support from the Migration Board to cover the cost. However, the following citation exemplifies that Migration Board staff sometimes make the final decision of access to health care due to a financial request from a hospital or other medical delivery unit:

*“...we can grant secure subsidy or specific means can be granted for such that is not really emergency either. If you judge that it has a huge impact for the person, that the person should not suffer disadvantage, from now on. However, it is rather strict nowadays. They receive certificates from us, physicians' and so on, that we approve that action taken and that and that. [...]If one could give some more prevention, it would be of use, there are so many of them who are here, that are staying, finally. Even if they turn aside or we can not force to execute return to the home country... [...]And years go by, and finally they can stay anyway. Then it is an ill person one have both physically and they have not received psychological help. Well, then that person does not become productive to the country's economy, if you look strictly”*

Participants stress the importance of access to health care to improve people's quality of life. The following citation is from a Swedish Red Cross regional programme officer:

*“However, it influences seeing that for asylum seekers it is nonsense because for them it is [need of medical] care, and they need it so they do not understand why they can not receive it? In addition, it is really, question marks and often they come here, and you can see it in their faces, and I understand them. On the other hand, we have laws and rules that control us, and the budget and the money and the economy and things like that.”*

#### Effects of financial threat

Medical care given at that stage when health has deteriorated must cost even more according to some respondents from both Migration Board and Swedish Red Cross health staff members. Both Migration Board and Swedish Red Cross participants explain that if care is not given when the asylum seeker needs it, their health will be further impaired and their suffering and health care needs increased.

Asylum seekers' impaired health is a barrier when receiving permanent protection visas or decision to return to the home country. The capacity to integrate is affected, is it possible to receive treatment in the home country for the impaired health status from the time spent in the asylum process, in Sweden? This aspect is highlighted by Migration Board staff that have worked with integration programmes before working at the Migration Board, as well as Red Cross programme officers and health staff members.

Migration Board staff refers to the decisions taken concerning access to health care according to the Governmental subsidy (in Swedish "scablonbidrag") that covers the cost for the County Councils for the emergency care given and the voluntary Health Control. The cost<sup>1</sup> that the asylum seekers adults pay on their own is a maximum of 400 SEK per six month and 50 SEK per visit. Cost over that has to be permitted contribution to the asylum seeker from the Migration Board. Hospitals and health care units ask Migration Board staff for financial support for a surgery or something else that medical doctors indicate is needed for the patient who is an asylum seeker. It is common among Migration Board staff to say that the medical doctor's decision is not to be questioned but there are others thinking about their decision concerning the financial support like the following Migration Board staff citation:

*"From case to case, an assessment is done to decide... What is maintaining life... Emergency what is that and what is preventing [health]? It clashes with each other then."*

Refusal of access to dental care is a major area of suffering that Migration Board staff members mentions while giving examples of refusal to care. In addition, Migration Board respondents explain that the refusal is based on financial arguments. The suffering for the asylum seeker is enormous according to the participants. Asylum seekers can often not eat proper food, only liquid nourishment. Another health aspect mentioned by Swedish Red Cross staff members and Migration Board staff members is surgeries in general are not performed at hospitals due to lack of financial support. Asylum seekers tell both Migration Board and Swedish Red Cross staff members that they are not satisfied with the access of dental and medical care that they need.

There are a few Swedish Red Cross regions struggling for the County Councils' acceptance of the need of a Red Cross Centres for Victims of Torture and War in the region, an acceptance that gives result in financial support to the activities. Other bodies' confirm the need of Red Cross delivery of health care to asylum seekers but the County Council denies according to the Red Cross participant, to contribute financially.

#### Explored actions to take concerning financial aspects of access to health care

There is a disparity of the financial aspects of access to care in different parts of Sweden as some Migration Board staff members say that they do not deny financial support if doctors indicate the need. A few do deny according to their interpretation of their duty towards the legal framework, here is one citation of a solution from a Migration Board staff that makes financial decisions:

*"However, it is necessary with clear instructions from the authorities to the primary health care centres and to others if one should lighten up that conception. But it is the law that rules us. LMA<sup>2</sup> and other things, the law about reception of asylum seekers, the physicians possibilities are limited, unfortunately it is like that."*

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<sup>1</sup> For the time when collecting data

<sup>2</sup> National law about reception of asylum seekers etc. (Lag (1994:137) om mottagande av asylsökande m.fl.)

Swedish Red Cross health staff explains that there are County Councils that do not deny financial support to hospitals if it is requested, that County councils administrators then ask Migration Board for a grant subsidy.

The Voluntary Health Control is free of charge for the asylum seekers and is an entrance to the health care system according to Migration Board staff giving information to asylum seeker according to follow citation:

*“The most important is to perform the Voluntary Health Control. There one receive guidance, help and it is free of charge. It is voluntary and you can not force any one to do it, but I tell him, it is the best for your own sake.”*

A dominant perspective from Migration Board and Swedish Red Cross staff members is the suspected positive financial effect as well as increasing life quality by taking care of an individuals’ small health problems instead of waiting until it become a severe situation for the asylum seeker.

Swedish Red Cross programme officers as well as Migration Board staff explain that a good health status of the asylum seeker also increases the capacity to integration if he or she gets a residence permit. Someone’s health should not deteriorate while staying in a country like Sweden. The current situation and a solution for improvement is explained by a Swedish Red Cross programme officer:

*“And everyone thinks this is important to bring the health perspective to persons just settled in the regions with a Permanent residence permit. [...]But everyone says; “What about the asylum seekers?” Everyone in the local authorities in the regions notice that it is so many that are so tattered that you noticed that nothing has been done before, and it might be humans waiting in 2,3 and 4 years in Sweden. However, they have not received any support earlier. And it would have been so much better if it had been in an earlier stage.”*

There are exceptional occasions where asylum seekers have received surgeries according to a few Swedish Red Cross staff, for example a liver transplantation.

Migration Board staff can also support asylum seekers health by giving financial support for spectacles, for example. A few Migration Board staff answer that at the refugee medicine unit (Flyktingmedicin) asylum seekers only receive paracetamol (“brand name Alvedon”) but then health staff can always refer to the Swedish Red Cross Centres for Victims of Torture and Wars for torture victims according to Migration Board staff in one region. A few Red Cross regional programme officers think about the value of giving self-treatment information to asylum seekers in that it might give a lower total cost for health care.

#### **Fourth threat: Geographical disparities of health care**

##### Threats to protection of health

The access to health care varies within regions and between regions for asylum seekers in general. There are also identified disparities to access of health care for asylum seekers with bad mental health or torture victims in need of specialised care, described by several

Migration Board staff members and Red Cross regional programme officers and health staff members.

#### Effects of threats related to geographical disparities

Within regions Migration Board staff members explain that the access to primary health care for asylum seekers in general varies between the Refugee medicine unit (Flyktingmedicin) located in the largest city in the region compared to the primary health care units in the outskirts of the region. One explored reason to the poorer access at primary health care units are according to participants due to little experiences of receiving asylum seekers. Another is the waiting time for the Voluntary health control is long in suburbs where many asylum seekers live.

In the northern regions of Sweden, both Migration Board staff and Red Cross participants highlight the lack of specialised care for asylum seekers, torture survivors and war traumatised. Participants have heard from other regions or noticed that some asylum seekers have special needs and explain that the health care is far away or does not exist. Participants also answer that if they try to refer asylum seekers with mental health issues to the County Councils specialised reception in another part of the large region, it becomes a financial issue or the access is restrictive. In a few regions both groups of participants explain that there is a nurse specialised for care for asylum seekers, but no physician is available, due to lack of physicians in these regions.

Migration Board staff at several reception units clarify that the issue of distance is the same for everyone in the region, not only the asylum seekers.

In a few regions, according to Red Cross staff the reception of asylum seekers is associated with a sense of panic due to more asylum seekers staying at housing provided by the Migration Board than the capacity of the unit allows. In a collaboration meeting between different bodies' the situation was discussed. The medical care was very poor due to too little capacity for care, but the children's situation was stable because the school was able to receive them all and support them.

#### Explored actions concerning the geographical disparities of access to health care

In regions with no or little access to specialised care for bad mental health and suffering from torture or war traumas, Red Cross and Migration Board staff members wish there would be increased care delivery to meet the needs of asylum seekers.

In some regions both Migration Board staff and Red Cross regional staff refer to a functioning Refugee medicine unit and answer that they experience that the asylum seekers are pleased with the access to care delivery at that unit. These specialised units/nurses collaborate in some regions with the Red Cross Centres for Victims of Torture and War for torture victims (SRCC). Migration Board staff refers to Refugee medicine who refers to the SRCC and torture survivors/war traumatised asylum seekers can get access to health care.

### **Fifth threat: Gatekeepers and care access**

#### Threat to the protection of health

Staff members of different categories and employers make decisions and become gatekeepers to care access. In this study several situations have been described by both groups of participants where asylum seekers have been denied access to health care, by different gatekeepers.

Several situations arose as described by participants whereby staff had to argue for the patient to be able to access care when a certain gatekeeper is denying access for example: physicians call the Migration Board, the Migration Board staff call to the hospitals, Red Cross staff must argue for the patient to access health care at other health care institutions, asylum seekers argue with staff at the Migration Board to facilitate access to health care and ask Red Cross participants what they should do. Medical care units call the Red Cross and ask if they can receive patients who are asylum seekers or irregular migrants, Red Cross volunteers call the Migration Board to see if care can be financially permitted.

#### Effects of gatekeeper as a threat to access

The receptionist at primary health care units and hospitals is mentioned by some Migration Board staff as someone who can affect the access to health care, sometimes denied access or as this citation explains:

*"... it is always a temporary worker in the reception. Someone who has not experienced this [asylum seeker without an id-number only an asylum id <sup>1</sup>] before. And then you have to stand there and explain how they are supposed to do there duties."*

The medical doctor and other health personnel can deny referral to specialist or entrance to care for both adults and children. According to Swedish Red Cross health staff a child was denied care as following:

*"There is the refugee medicine unit where they can go, but many times, what they say to me is that they are not satisfied with the help they get there,[...] it feels like they are so restrictive in sending them on further investigations from there. So the doctor often stops there, treats them there instead of what they think they want..."*

Both Migration Board staff and Swedish Red Cross health staff have experienced that children under 18 years are often denied access to a hospital or primary health care centres. The participants most common explanation is that health staff does not know that asylum-seeking children have the right to same access as children who are Swedish citizens and sometimes children and their parents are referred to the Refugee medicine unit.

Red Cross volunteers have experienced situations with asylum seekers with denied residence permit application claiming being torture survivors. This was hard to prove according to the participant. The asylum seeker had thoughts of committing suicide. The volunteer described the situation very difficult in many aspects, the legal representative (juridiska ombudet) and the volunteer did not know what to do or to whom they could refer the person to evaluate if person had suffer from torture. No access to specialist care was supported. Red Cross volunteers in another region have met asylum seekers with mental health problems, and then the Red Cross representative contacts the municipality staff that contacts the psychiatry unit in the region and asks for a consultation for the asylum seeker. Migration Board staff in a small community with asylum seekers living in housing provided by the Migration Board can also be a gatekeeper to access to healthcare. If Migration Board staff think it is not urgent or it is something like back pain the asylum seeker receive information to not call the ambulance

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<sup>1</sup> LMA-card. Personal document with photo. The document is called Temporary LMA-card for Foreigner in Sweden. The expiration date of the LMA-card varies due to the estimation of the Migration board on how long the foreigner will be affected by the law of reception of asylum seekers and others. It cannot however be valid more than six months. (Translation by author) In Swedish; LMA-kort. Source: <http://www.migrationsverket.se/swedish/verket/migrfs072005.pdf>, retrieved 19 Aug 2008.

with the explanation the ambulance have to be kept free for really urgent matters. On the other hand according to the following citation Migration Board staff in the same region makes access available to asylum seekers health care unit like follows:

*"I think it is that the health care is so accessible. [...] if one is ill, then they need to contact us, they call, or [...] when they see my colleague for instance, driving around in his car, they just wave. And ask to get an appointment. Then he calls, they [health care unit] fax an appointment, then they receive that in their hand just like a bus ticket. So they can come here without cost and receive the health care, so it is there all the time."*

To realise access for a seventeen year old child a Red Cross health staff members describes the following argumentation:

*"... it concerns an asylum seeking child with deformed feet who has a really hard time walking. [...] The doctor [at the refugee medicine unit] referred him to the orthopaedic and it takes a year to get there. I have tried to speed up the process. But that did not work. The doctor has to do it and the doctor doesn't want to do it. The doctor doesn't want to speed it up, the doctor think that the child has had it like that for 17 years [...] But I see [] he is in pain, and he plays football so I know he won't be able to sleep all night. But he is young and a boy, and he wants to be a part."*

Migration Board staff explains that asylum seekers that are not receiving health care, contact the Migration Board staff to receive help. Some Migration Board staff members describes that they try to support asylum seekers through letting them talk it over, a few staff members give health care information to support the symptoms and others encourage asylum seekers to accept the situation. This citation exemplifies a Migration Board staff conversation and arguing with an asylum seeker denied health care:

*"We argue and I try to motivate the person put up [with the situation]. Moreover, find alternative things so it will not hurt or something like that. Talk about it all. I have experienced talking about it up to 10 times, at different occasions, where the asylum seeker does not want to accept the whole [not receiving health care]."*

An argumentation situation between different bodies' concerning questioned right to access to care because of risk for infectious diseases is described by Migration Board staff as an example of gatekeepers to access. This situation is from a detention, described by one Migration Board staff:

*"Once there was a patient who collapsed and almost became unconscious. We called the ambulance, at the detention, and now he had had surgery in another country, the heart valve I believe it was. And the ambulance **refused** to take him in the ambulance because it could become infected and it could take them three hours to clean this ambulance. Then I and my colleagues had to ARGUE to make them take this man in the ambulance, to the hospital. The ambulance personnel on the other hand had to call the hospital to get permission for this, to come in and so on and so on. So sometimes it is really tough!"*

A few Red Cross regional programme officers describe asylum seekers that are HIV- positive contact the Red Cross to get help to understand why they do not receive any medical treatment from the County Councils health care unit. Red Cross staff say they does not know the answers.

### Explored actions to take, gatekeepers as facilitators of access to health care

The access to health care has increased according to participants from the Migration Board and Swedish Red Cross health units in different parts of Sweden due to a special nurse employed with responsibility to make Voluntary Health Control as well as making the first assessment of the need of medical care. Here it varies what the nurse can do according to different answers from both groups of participants in the study: The nurse can identify patients with special needs, the nurse can contact specialists and refer asylum seekers to specialist after confirmation from responsible physicians', the nurse can be contacted by Migration Board's staff if an asylum seeker is in urgent need of a consultation and the nurse can arrange quickly a time for consultation as well as an interpreter. Migration Board staff and the nurse can discuss issues concerning individuals within the limits of confidentiality; the nurse is available and has an open door. The nurse can identify torture survivors or war traumatised but not refer them to the hospitals due to the limitation of the law, but to the Swedish Red Cross Centres for Victims of Torture and War of torture victims (SRCC). Following citation from a health staff at SRCC exemplifies the nurse as a facilitator to access:

*"Yes the last few years a new thing is the asylum nurses, who have a special task to take care of asylum seekers, health control and after that there is often a referral to us because some of those that are sick, then a referral comes to us. That's how it is, there has been improvements in that area. So there is, now there is an accessibility that wasn't there a few years ago, just because there are appointed asylum nurses."*

In a few regions Migration Board staff members have a contact person at the County Council and this contact person has a direct contact with the County Council different health care delivery units. If some patient has been denied a Voluntary Health Control by staff at primary health care centres the contact person is informed by the Migration Board staff, and then the contact person clarifies the routines for the unit that has denied care and the asylum seeker can then do the health control.

A few of Migration Board staff members request that the County Council could facilitate their information to their own employees on how to perform the routines with registration and treatment of asylum seekers as patients, including the children's rights to access.

In some regions Migration Board participants stress the importance of telling the parents who are asylum seekers to know the rights of their children to access health care. So parents know their children's rights if they are refused access.

Here is another solution of gatekeeper as facilitators to access for asylum seekers living in housing provided by the Migration Board described by Migration Board staff;

*"We always keep our cell phones on. Then they also get information, that if you are sick, nothing life threatening, but you feel you need medical care evenings or weekends when it is closed here, they just call me or my colleague, we call an ambulance or a taxi that take them to the city X."*

Red Cross volunteers' acts like facilitators towards gatekeepers in the health care system, they answer that they follow asylum seekers to hospitals, the maternity unit and the birth delivery department. They also support with phone calls and call before an appointment to arrange interpreter, here is another example of action taken to facilitate access to health care by a Red Cross volunteer:

...”[the primary health care centre] they have an open reception, certain hours, twice a week, for the asylum seekers. There are two doctors working at that reception. And when I ask them to give them a certain appointment they make no exceptions. Only a few times I have been given that. Because they have such bad experiences that they don’t show up, they don’t come on time...[.]. And there was this one woman [...] after two hours she couldn’t sit and wait anymore, this happened a couple of times. For her I wanted a special appointment. And she got it, they made an exception”.

Staff admit that they try not to harm other bodies’ representatives’ responsibility or authorisation while securing protection to asylum seekers access to health care.

### **Sixth threat: Availability of access to health care**

Under the sixth and final explored threat to protection of health, there are two identified sub themes linked to the availability of access issue; *Information & information routines and Technical-language & cultural issues.*

#### Threats to access to health care

Different bodies’ activities and representatives can be a threat to the access availability. The way staff performs their duties or how working routines are organised can be a hinder to availability according to both Migration Board and Red Cross participants.

Described by a few Red Cross health staff members, is that the time to wait for the Voluntary Health Control is too long for the newly arrived asylum seekers, especially when many asylum seekers suffer from bad health on arrival. Participants from both groups say that even if people are healthy when they arrive in Sweden, the prolonged asylum process has a negative effect on their health.

#### *Information and information routines as a threat*

Between different bodies’ and asylum seekers the routines for giving and receiving information varies. A few participants states it is difficult to control if asylum seekers receive a letter calling after the Migration Board has informed the health care unit in the region. Routines vary between Migration Board participants description of how to give the information to asylum seekers about their rights to aid benefits<sup>1</sup>. Some participants give brief and general information in a short amount of time as there is lot of information to provide at the first registration meeting.

In some Migration Board units only the asylum seeking men are participating in the information meeting which is an important gender perspective to improve, according to Migration Board staff members.

#### *Technical- linguistic- & cultural related issues*

Several Migration Board staff members, Red Cross health staff members and volunteers explain that asylum seekers have both technical and language barriers to access health care, because many health care units are only available by telephone. A few Red Cross health staff members say that in general, language is a barrier to access.

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<sup>1</sup> In Swedish: Biståndsförmåner enligt Förordningen om mottagande av asylsökande 1994:361, §2

A few of Red Cross regional programme officers and Migration Board staff members expressed that people have different approaches to medical care for cultural reasons. A Red Cross staff talked about the “Evil Eye” is the cause of illness if you are Turkish and that might affect their view of medical care.

Migration Board staff members describes information provided to asylum seekers concerning health aspects of living in Sweden. One example is, if you have a sore throat in Sweden according to Migration Board staff one should use a warm scarf around the neck or eat ice cream and it is common to have at least two colds’ per year according to staff and you do not always need antibiotics. Here is another exploration of cultural issues according to Migration Board staff:

*“I have met people who used to go to traditional medicine doctors. In different African countries and they have been vaccinated against different snake bite by a deep cut along their arms where the poison from the snakes have been poured. And it has become terrible scars on the arms, but it has not been torture or maltreatment, it has frankly been vaccinations, laugh, so this is very mixed...”*

Both Migration Board, Red Cross health staff members and volunteers describe different aspects of working with interpreters. One issue is that the information given to asylum seekers is always third hand, through an interpreter. If health staff members are not used to working with interpreters this affects their consultation with the asylum seekers. A few Migration Board staff members also described the effect of this is that asylum seekers can often experience the sense that they are not being taken seriously.

#### Availability to access, Effect of threats

Asylum seekers physical and psychological situation when getting access to a Swedish Red Cross Centres for Victims of Torture and War of torture victims is described by a Red Cross health care staff:

*”...They experience that they don’t get their health taken care of during this [asylum process].[...] many times, they often have poor health and when they come here as patients and get to meet our doctor she becomes, well, not loaded in a negative way, but they express their needs then, and then follows a lot of parallel investigations and treatments at different clinics at the hospital, they often have many visits. [...] Their physical health worries them even psychologically, on top of the insecurity during the asylum time, so that they, yes they feel worse, both psychologically and physically, worse than they would have otherwise, if they would have received treatment earlier and maybe much broader than just the most necessary.”*

#### *Information and information routines*

Described by a few Migration Board staff members is the importance of functioning routines at the Refugee medicine unit. Compared to general primary health care centres in the outskirts of the region that might receive a few asylum seekers per year, where staff members for example do not know what blood test that are included in the voluntary health control.

#### *Technical, linguistic and cultural related issues*

When access to health care is available by phone one must with button prints and with personal identity number (In Swedish: personnummer) register the first contact with the health care centre. This is difficult without Swedish citizen id-number and to handle purely

linguistically, for some patients it is not possible. Following Migration Board staff citation exemplifies:

*“...the problem with these healthcare centres is that most often have introduced some system that does not correspond with the reality. One take for granted that everyone can read and to speak in telephone, and to book a time and make an appointment. It does not function like that on all occasions.”*

A few of Migration Board staff members also expressed that asylum seekers trying to contact health care centres personally to facilitate an appointment with health staff sometimes are referred outside the health care unit to make the reservation by a phone call.

A few of the Red Cross health staff members explained that some patients might seek medical consultation frequently to receive confirmation of a physiological diagnosis while it is really a mental health issue. The following citation explains the reasoning:

*“...for example severe head ache, but one can not find a physiological reason, one continues to go to physicians because it must not be mental, and it has to be something somatic. One [the asylum seeker] treads water...”*

#### Explored actions to take to protect health

##### *Information and information routines*

Some Migration Board staff members gives more detailed information, with maps or telephone calls concerning how to find the delivery ward, maternal- and child care or another unit. To ensure that pregnant mothers know exactly how to find their way to the delivery unit, is important. A few Migration Board staff members had a direct personal contact with the nurse responsible to make the Voluntary Health Control. In some cases Migration Board staff can contact a nurse or the health care delivery unit if there is a question concerning the asylum seeker's need of health care.

Other information that is important to give asylum seekers is exemplified according to the following Migration Board staff:

*“When we have the registration meeting they get information on where we are, how we are available and how you call the ambulance , and that it is important that you know your address so you can reach someone who speaks good English or Swedish then, so that you can explain the problem. So that you can explain what the problem is and where they can find me.”*

A few Migration Board staff gave detailed information and support the asylum seeker to contact the health unit by phone, gave map explanation how to find the way, addresses and written information.

In a few regions the Refugee medicine unit has stressed the importance of all children to access Refugee medicine unit, so Migration Board staff makes an extra effort to support this by informing the asylum seekers. After asylum seekers have come in contact with the Refugee medicine, they have the responsibility for health related issues. A Migration Board staff describes in this citation the routine involved in the Voluntary Health Control:

*“ In city X we have a Refugee medicine reception, called reception Y. And it is there one make an appointment for the health control. Of course we ask if they want to have it, we put in an application, reception Y summon. That is the chain. And we have a lot of contacts with reception Y [...] It is that contact that is valid between reception Y and the asylum seeker. And we have so much contact with reception Y, they call us and ask if there are special things. And what one can talk about one talk about [due to secrecy], and it is the same from Y to us”.*

Migration Board staff members in one region give information about HIV and AIDS to asylum seekers, to all or to only asylum seekers from Africa this was not known by participant in the study. The information and routine was not explored in the interview.

A few Red Cross regional programme officers also requested more information about health issues, health care delivery units and collaboration with Red Cross health staff and Red Cross head quarter Health and Social welfare department to be better prepared for health related issues and questions.

According to Both Migration Board staff members and Red Cross regional programme officers information of self treatment in various languages were requested.

#### *Technical, linguistic and cultural issues*

In the bigger cities reception units for emergencies are open at night where one is not obliged to make the appointment by telephone call according to Migration Board staff, so asylum seekers go there to receive consultations. One respondent from the Migration Board also explained that the Refugee medicine unit with special focus on asylum seekers in their region has facilitated access by open reception or a direct telephone number to the nurse to facilitate access.

Several of the participants from both Migration Board and the Red Cross stress the importance of using an interpreter of the same gender as the patient, especially on some occasions related to intimate issues. This is how one migration Board staff explains it from a gender perspective of a man:

*“ There are people from different parts of our surrounding world that cannot to speak if they suffer from genital pain or if they have a venereal diseases, or talk about that part of the body. Especially if it is a man who search for a consultation, and meets a female care giver and even a female interpreter, you can see by your self how difficult it becomes. [...] I call for bigger knowledge by the care personnel [...] to work with interpreter! But it is not of course my responsibility; it is of course the county councils’.*”

Interpreter issues are described from a gender perspective by both Migration Board staff and Red Cross volunteers. The following citation is from a Red Cross volunteer supporting a woman:

*“It was a woman that had difficult pain after an abortion, and did not dare to go on follow up visit. She had gone once and then it was a male physician then, she turned in the door and left. And her husband requested to me for support and I promised to follow her, then I called to make a consultation [...] both female physician and interpreter. They arranged it. [...] Both her husband and I stayed with her all the time during the examination [...] She was carefully examined, and she got advices. Not so much, it was nothing serious, but it could have been.”*

Sometimes it is not possible to arrange an interpreter with the same sex as the asylum seeker when it is urgent matters. Exploration of a solution is described by the following Migration Board staff citation and experience:

*“I have been with women to the gynaecological clinic because they have been exposed to assault of different kind... and on some emergency occasion they could not arrange a female gynaecologist and it turned out well actually, better than expected, and the physician took his time and explained everything and the women was very thankful afterwards.”*

A few of Migration Board staff and Red Cross volunteers have asked female pregnant asylum seekers in the late part of pregnancy from countries where genital mutilation is commonly used if the women has been opened (defibulated to allow the passage of the baby) to give birth. This question has been asked by both groups to ensure them that there would not be a need for support to the women to get access to care to prepare her for the birth. In that case she would require support to care contact as soon as possibly.

### ***Staff needs of support to protect health***

The second part of the results is the explored answers from participants' perspective if they received support to do their work by means of education in Human Rights and supervision. Overall the second part of results (table 6) revealed the main theme: Staff needs of support to protect health, presented below with sub theme of there answers organised in having or not having Human Rights education and supervision.

## **Education in Human Rights**

### Exploration of Swedish Migration Board staffs' education in Human Rights

Several of Migration Board staff members say that they know what Human Right is, at least as much as having knowledge of the topic, staff also describe that the Conventions against Torture and the Child Convention is included in there. Eight of the participants had participated in the one or two day course in Human Rights within the Swedish Migration Board internal staff education programme with different courses and levels to pass through. A common answer is that staff members appreciate the “Migrationsprogrammet”<sup>1</sup>. Three of the participants had a university degree in Political Science, including Human Rights, and one participant had no education in Human Rights at all. Some of the participants graduated from a school of social studies<sup>2</sup> and few of those participants said education in Human Rights was also included in the professional education.

### Exploration of Swedish Red Cross participants education in Human Rights

Red Cross regional programme officers explained that refugee issues and Human Rights issues are in some ways divided in the Red Cross due to different responsibility of staff. There are educators in Human Rights and there are staff working with refugees, family reunification and tracing issues. The question of this division is a delicate issue according to a few participants. Two of the Red Cross regional programme officers have a university education in Human Rights, five of the participants had participated in the Red Cross education in Human Rights and one had no education at all. A few of regional programme officers asked for more detailed education in Human Rights to better do their daily work.

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<sup>1</sup> It is the education programme for staff at the Swedish Migration Board provided by the Migration Board.

<sup>2</sup> In Swedish: socionom

The volunteers described that to be a volunteer in the Swedish Red Cross one is obliged to participate in the Human Right course, and one can do it several times to refresh the knowledge. Both of the participants had participated in the Red Cross Human Right's course.

Among Red Cross health staff members five of six had not participated in Human Rights education neither in their professional education nor in the Red Cross courses. A few described that Human Rights education is part of their daily work. One staff has education in both political science and health profession and described that in university courses in Human Rights, there is not focus on health as a human right and in the health professional education Human Rights was not mentioned.

## **Supervision**

The second sub theme of the results within the theme staff needs of support to protect health is supervision to staff and volunteers. For an overview of results with sub themes, see (table 6).

### Exploration of answers from Migration Board staff having supervision

Eleven of twelve Migration Board participants responded to the question of supervision. Eight of the participants respond that they have supervision. The frequency of those who have supervision varies between every second week, once a month and not as often as staff wish.

Among participants having supervision staff described that it is important to have supervision, to get guidance of how to handle situations when you met asylum seekers. A few staff had only had supervision for a short while and they were pleased with this new support to do their work. Participants had mainly supervision with their colleagues in a group. A few said that if needed they could request individual supervision as well, and a few had individual supervision as well as with the group. Staff members explain that there is working related supervision that is concerning how to work together as a group and what to think about in the asylum process and how to do the process. Among the other participants' descriptions of their supervision the answers vary; how to deal with difficult situations like negative decisions to give to asylum seekers and threats towards staff members as well as what to do when asylum seekers do not feel good, with mental health issue. Staff can talk with less restriction in reference to secrecy about what bothers them. One participant described supervision organised in a different way than the other participants. It was as follows: there were 5 staff members in a group with a psychotherapist as a supervisor. They talk about how to handle people exposed to very difficult situations, two hours education in social science and two hours case related education. Some have supervision at their Migration Board units while some participants meet the supervisor in another environment, outside the office. The following citation about supervision is such an example:

*“Yes, supervision we have, once a month, at a hotel in town, we go there so we can leave the house for a while. We think it has functioned well, we have not had it for a very, very long time.[...] it is in a group, but there is opportunity for individual if we think we would need it[...]. But it was most about really, well this situation. I thought it was a little bit tough, so it is good that we could share that, all of us. It is easier to support each other, if it is tough, of course it is tough.”*

Both participants with supervision and no supervision highlight the value of support from the colleagues as an important part of informal supervision. One respondent explained the disadvantage of this under the following sub theme of not having supervision.

#### Exploration of answers from Swedish Migration Board staff not having supervision.

Three of participants did not have supervision. The answers varied, one staff said that it varies what staff is offered, sometimes they have supervision and sometimes not, now it was a long time since the last time. One staff explained that the group of staff does not need supervision because they could talk with each other in a fruitful way. It is important to be able to separate work and free time. If one can not do this, supervision is needed. One staff had requested supervision but did not receive it, as this citation exemplifies:

*“I would have been very glad if I could have had supervision...[] I divide supervision into two kind, how we are supposed to do the process, how we work together and what I should think about, what one should work with. While case supervision we do not have. To me that is very important while you work with people in crises. Moreover, if you feel bad yourself or have been through something difficult and you go and talk to a colleague you are confident with and that colleague as well has a lot on his/hers shoulders, and maybe have been through something traumatic, and that is not good as a matter of fact.”*

#### Exploration of answers from Red Cross participants having supervision

Swedish Red Cross Regional programme officers answered that supervision is important. Five of eight participants have supervision with regular frequency of every second week, once a month and one time last year. The Swedish Red Cross regional programme officers are supervisors themselves to Red Cross volunteers dealing with asylum-seekers issues and support them in the asylum process and family reunite matters. To walk away from the office to another place for supervision is positive according to a few participants. It varies between participants what they think are important qualifications of the supervisor.

All health care staff participants have supervision either individually or in a group with the colleagues. Health staff did give short and simple answers that they have supervision and everyone said it worked well for them the way it was organised. Only one respondent mentioned that on a few occasions the supervision had to be cancelled because of too many patients to consult. The Master student did not explore the supervision question with probing questions to the participants so the answers were not explored on a deeper level. One of the volunteers has supervision by a Red Cross Regional programme officer as supervisor or sometimes from a lawyer.

Red Cross Health staff members as well as regional programme officers and volunteers describe the positive value of the support of the colleagues as a part of the supervision for participants' individual work with support to asylum seekers

#### Exploration of answers from Red Cross participants not having supervision

Three of Red Cross regional programme officers did not have supervision as well as one of the volunteers. Reasons of not having supervision were described as hard to find a supervisor, no permission to have supervision and one answer was that respondents thought support from colleagues is enough as shown by this citation:

*“It was hard to find a good supervisor that knew about these matters [...] I had to explain too much. [...] Now when I have colleagues that do the same things, I think we fulfil that purpose amongst ourselves. We talk about things and so on. If we needed it, we could go to a supervisor. I know that, there are no economic hindrances or so.”*

A few respondents answered that they have the freedom and possibility to arrange supervision, but it is difficult to find a supervisor who knows topics concerning refugees and asylum seekers as well as how it is to work in a non government organisation (NGO). A few participants had no colleagues working with the same tasks at their office and no professional supervision. Obstacles to supervision described by different participants were such as in small towns those who are qualified to be supervisors are also in the participants' personal network and therefore it is not possible for them to be supervisors. There are staff members who tried for a long time to get the permission from an employer to arrange supervision and finally got a yes. Another obstacle described by participants was because of work circumstances staff have not been able to participate in supervision on a regular basis. The final description mentioned was the supervisors understanding of the topics the participants wanted to discuss were limited. A few participants answered it was a hindrance if participants have to explain the topics to the supervisor although one respondent thought it was not an obstacle.

## **6. DISCUSSION**

### ***Results***

Two main themes are identified; Threats to the protection of health for asylum seekers in Sweden and staff needs of support to protect health. The major finding is the gap between the right to health according to international Human Rights law, and the current situation, with lack of access to health care for asylum seekers in Sweden due to the six identified threats of this study. Findings also indicate actions to take to improve the protection of health.

The legal limitations (Swedish Government 2008a) create situations for participants and asylum seekers whereby they have to argue for the right of access with no certainty as to the outcome. There is a conflict between the ethical codes of nurses and physicians (World Medical Association 1949; International Council of Nurses 1953; World Medical Association 1964) and the interpretation of the legal framework. The conflict becomes clear when health staff contact Migration Board staff and ask if the care they need to give is covered by the legal limitations of access to health care.

On a few occasions the decision regarding health care access has not been made by physicians, but by Migration Board staff based on financial considerations.

There are geographical disparities regarding care access for torture survivors and asylum seekers mental illness in the northern part of Sweden. Both Migration Board and Red Cross participants highlight that specialised health care for asylum seekers with mental health issues and torture survivors is not available or is difficult to access. This is a threat to the capacity to test refugee claims, as asylum seekers may be refugees (UNHCR 1992). For people suffering from trauma, and torture survivors, it is also of great importance to obtain treatment early in the emergency phase of a post-conflict situation (Mollica, Poole et al. 1997; Modvig, Pagaduan-Lopez et al. 2000). Mental ill health and dental problems were highlighted by a majority of participants where there was not enough access to medical care.

There are some encouraging findings concerning those who facilitate access to health care, such as nurses at refugee medicine units or Red Cross volunteers. Participants also describe health staff giving treatment to asylum seekers for humanitarian reasons. Nurses as gatekeepers can facilitate access and this has also been studied in the United Kingdom (O'Donnell, Higgins et al. 2007). In those regions where there is co-operation between

different bodies the participants described access to health care as good. However, access is still limited by the legislation. Interpersonal contacts between staff at the Migration Board and the County Council refugee unit increased access to health care for individual asylum seekers.

Children are denied access to care; the reason for this is found to be a lack of knowledge about the rights of children by those who deny access, the gatekeepers. This leads us to the second major finding; staff needs of support in protecting health. Not all of the participants have supervision and not all have training in Human Rights. Levels of training varied. The Migration Board staff did not request more training in Human Rights but several participants reported needing supervision. Among the Red Cross participants there were some that did not have supervision, not all those without supervision requested it, but the importance of supervision was highlighted by a majority of both groups of participants. Among the Red Cross participants there were several who requested training in Human Rights for the practical meaning of the right to health for daily activities, a “tool-kit” to use in difficult situations.

### ***Limitations***

Four possible limitations were specifically considered and how they were counterbalanced is presented below.

First limitation was my position of working at the Swedish Red Cross head office. The risk of bias was considered little though I have no impact of the participants work. We were not associated even though we have different tasks within the same non governmental organization. Informed consent both orally and written scored confidentiality and respect for the participants as well as the possibility to vet the results before publishing. Both Migration Board and Red Cross participants spoke freely mentioning positive and negative factors about their daily work and organizations.

Second limitation was the issue of not having relevant questions in the interview guide. To decrease this limitation the participants in the pilot study represented the different categories of participants for the study. The pilot study was an important part of the construction of the interview guide as each interview made us revise the interview guide according to the participants' evaluation and spontaneous feedback. At several occasions the relevance of the interview guide was confirmed after the interview by the spontaneous feed back from the participants: “this was fun/you made me think of new issues/ the questions were relevant”. Comments after the interviews were recorded as field notes according to qualitative methods (Dahlgren, Emmelin et al. 2007) and became a complement to the data and to the whole picture.

Third possible limitation was the author, with little experience of conducting interviews. Debriefing after each interview with the main supervisor was one way to counterbalance this. The semi-structured interview guide provided consistent to the sessions. The interview situation and the authors own experience was also discussed with different perspectives and experiences within the research group, Migration and Health, headed by the main supervisor.

The fourth possible limitation is the fact that asylum seekers have not been included in the presentation of the data in this study but asylum seekers are included in the data collection and design of the bigger research project where this study is one of three studies. Asylum seekers own perspective will be illuminated in a case record study and case interviews (see Appendix 1, Project Plan) and the results will be presented in future publications.

## ***Conclusion***

The UN Special Rapporteur for the highest attainable health, Mr Paul Hunt, said in a hearing (2008) directed at Swedish public officials “ *A new arrangement is needed to be effected that is based on Human Rights, justice and non-discrimination*” (Parliamentary Hearing, 2008, broadcast). The present study can confirm the gap between the access to health care in Sweden compared to international legal instruments implementing health as a human right. There are also findings indicating actions to take in order to improve the protection of health. It is important to remember the relationship between protecting health and dignity; “*health and Human Rights are complementary and interconnected approaches towards sustainable human development and the advancement of human well-being*” (OHCHR 2002, p.6). To protect health as a human right is important for each individual’s quality of life but also because recognising Human Rights “ *is the foundation of freedom, justice and peace in the world*” (UN 1948, p.71).

Not all asylum seekers are suffering from severe trauma or torture. However, it is important to provide access to health care with specialised assistance for those who are suffering from severe trauma and torture (Global Consultation on International protection 2003). According to Steel, Frommer et.al. (2004b), the use of correct psychological evidence as a part of refugee determination is a challenge for mental health professionals and decision makers concerning asylum applications. These authors report that complex traumatic effects on mental health can be misunderstood by decision makers. On the other hand, health professionals must obtain appropriate testimonies or clinical findings that can assist decision makers in examining the refugee claim. In 2007, only forty-five per cent of asylum seekers in Sweden participated in the screening program, the voluntary health control (SALAR 2008). According to the results of this study many asylum seekers do not obtain access to clinical examinations by health professionals, due to the limitations of the law and gatekeepers refusing access. However, there are patients receiving specialised care, but this is not available in all parts of Sweden, according to the findings.

Refusal to give health care to asylum seekers concerns different levels: public policy level regarding the legal restriction; community and organisational level where there is a lack of, or non-existent, medical care, especially for torture survivors or those with bad mental health; individual level where asylum seekers try to obtain access to medical care but are hindered by gatekeepers or information routines and technical barriers. However, there are also possible ways to improve access.

The UN Rapporteur on the highest attainable health (Hunt 2007b) reported that in Sweden 2006, there were health professionals who had not received training in Human Rights. This was also found in this study with a few participants from both the Migration Board and the Red Cross having no education in Human Rights. How can one protect health as a human right without knowledge of Human Rights?

After the interview many participants told the author that they hoped that the study would lead to changes, and that asylum seekers’ situation related to health would improve. The author replied that the results would be distributed to participants and that interventions regarding improvements will be based on the results.

## ***Implications***

The results of this Master thesis suggests implications for different levels of action to recognise the “*dignity [...] of the equal and inalienable rights of all members of the human family*” (UN 1948 p.71). This study has implications for increasing the protection of health as a human right for asylum seekers in Sweden at individual, community, organisational and public policy levels. It also indicates new research questions.

Individual level: Asylum seekers need access to health care in general. Those who are at special risk, torture survivors and those suffering from severe trauma or infectious diseases have to be identified early in the asylum process. Asylum seekers in general have to be protected from ill health so they that can integrate into society or return home. It is especially important that children are not denied access to health care according to the Convention on the Rights of the Child (UN 1989).

Improvements are needed concerning staff training in Human Rights and the provision of a practical “tool-kit” for daily work. It is important to provide supervision for staff and volunteers. Staff interventions are preferably carried out using evidence-based methods such as those used in a project concerning intervention aimed to increase knowledge in a transcultural setting (Shahnavaz and Ekblad 2007).

Community level: There are disparities in access to care between different parts of the country. How can specialised care be accessible and available to all asylum seekers who has the need of it? It is important to provide professional health care to asylum seekers with bad mental health and torture survivors.

Organisational level: Nurses and Red Cross volunteers as facilitating gatekeepers as well as co-operation between different bodies’ are important improvement factors of health care access and require further evaluation.

Public policy level: Free health and medical care as provided in several countries is a good model (Global Consultation on International protection 2003) as well as limiting the length of time for the asylum-seeking process. Access to dental care is an important aspect of asylum seekers’ health as severe dental problems prevent people from eating and talking. Furthermore, as declared by the European Academies Science Advisory Council; “*Detection of disease on screening must not be used as a reason to deny entry to the EU, for that would deter migrants coming to screening and the identification of high-risk patients. Migrants need to be offered the same access to healthcare services as the rest of the population*” (EASAC 2007, p.1)

### Future research questions

- How and by whom, can the identification of specific health needs of asylum seekers be guaranteed?
- What are the impacts of the protection of asylum seekers health if staff/volunteers receive education in Human Rights, including a tool kit for daily work?
- What are the current uncertain issues concerning infectious diseases and asylum seekers?

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# APPENDIX

## Appendix 1



### Project Survey and dialogue for the purpose of health promotion in asylum seekers

01/08/2006 – 31/12/2008

#### Background

Health is a self-evident right for all people according to UN's universal declaration of Human Rights (1948). Health is also an important prerequisite for integration into and participation in Swedish society. However, the right to health is not obvious to everyone in Sweden. At the Red Cross throughout the country we see through our various activities and encounters with asylum seekers that many people feel very bad and do not receive the support and care they need. We believe we know that it would be possible to better attend to the needs of asylum seekers if co-operation between different bodies were to improve. At a national level there is an agreement between a number of authorities and institutions on "*National vision regarding health and the initial period in Sweden*" (2004)<sup>1</sup>, commonly called "*the health platform*". This agreement constitutes an important basis for how co-operation at local and regional level should look. The health platform also mentions important areas for change with improved co-operation between health care and introductory activities/activities preparing for introduction in order to identify and take care of physical, psychological and social risk factors for disease. The project is partly financed by the European Refugee Fund (ERF)<sup>2</sup>.

#### Purpose of the project

To improve the health situation of asylum seekers by means of

- a **study** which maps the Swedish Red Cross', the Swedish Migration Board's and other bodies' activities for asylum seekers in Sweden, examines co-operation between different bodies, identifies shortcomings, possible solutions as well as good experiences.
- **dialogue** with different bodies concerning the findings of the study which will result in providing tools which help us move from knowledge to practical and concrete action.

#### The project's objectives and schedule

**Overall objectives:** To promote asylum seekers' health.

**Partial objective 1:** Scientific study conducted **Period:** 01/08/2006 – 31/12/2007

**Activity:** A survey to map activities and co-operation which promote the situation and health of asylum seekers.

**Mapping includes:** The Red Cross' and the Migration Board's activities and experiences of co-operation between different bodies as well as knowledge of asylum seekers' health requirements. Asylum seekers' requirements, which measures have been taken and by whom. Identification of areas for improvement as well as good examples.

**Partial objective 2:** Dialogue, distribution and intervention of the study's results and recommendations

**Period:** Continuous dialogue during the project, distribution of results from 01/06/2008 – 30/09/2008.

#### Method

1. Semi-structured interviews approximately 30 interviews with Red Cross and Migration Board participants as a total geographical investigation of Sweden
  2. "Case book form" – 45 case books, 3 per Red Cross staff to investigate asylum seekers' requirements, which measures have been taken and by whom
  3. Semi-structured interviews, 4 "case" – 4 persons who received permanent protection visa
- The study is performed scientifically and is led by 2 scientists at Karolinska Institutet (KI) as well as the Institute for Women's and Children's Health at Uppsala University.

#### Intervention


- Dissemination of knowledge internally and externally throughout the country.
- Dialogue with relevant bodies in order to plan activities based on the study's results.

#### Target group

- Personnel at the Red Cross as well as the Swedish Migration Board who work with asylum seekers
- People who have recently received permanent residence permit, previously been asylum seekers, people who received care at the Swedish Red cross health care service for undocumented migrants and the Swedish Red Cross reception centre for undocumented migrants and Swedish Red Cross centres for tortured victims (SRCC).

For further information, project manager: Maria Stålgren, +46 8 452 46 20, [maria.stalgren@redcross.se](mailto:maria.stalgren@redcross.se), [www.redcross.se/prohealth](http://www.redcross.se/prohealth).

<sup>1</sup> [http://www.mkc.botkyrka.se/biblioteket/Publikationer/nationell\\_samsyn\\_web.pdf](http://www.mkc.botkyrka.se/biblioteket/Publikationer/nationell_samsyn_web.pdf)

<sup>2</sup>  [http://ec.europa.eu/justice\\_home/funding/refugee/funding\\_refugee\\_en.htm](http://ec.europa.eu/justice_home/funding/refugee/funding_refugee_en.htm)



10 maj 2007

**Till regionchefer i Röda Korset.**

Vi vill inbjuda era medarbetare som arbetar med asylsökande att delta i forskningsprojektet "Kartläggning och dialog för att främja asylsökandes hälsa".

Studien är granskad och godkänd av Regionala etikprövningsnämnden i Stockholm, diarienummer: 2007/206-31.

Studien delfinansieras av Europeiska Flyktingfonden (ERF).

*Syftet med projektet är att främja hälsa för asylsökande.*

I studien kartläggs bland annat vilka insatser Röda Korset och Migrationsverket gör, vilka behov de asylsökande har, vad andra aktörer gör, hur samverkan fungerar, goda exempel och vilka brister som finns.

Det är viktigt att vi får kunskap om erfarenheter som finns hos den enskilda handläggaren av asylärenden, behandlarna på Röda Korsets center för torterade (RKC) samt Röda Korset sjukvårdsförmedlingen för irreguljära migranter (gömda) i Stockholm. Vi har därför valt att genomföra enskilda intervjuer med handläggare/behandlare från Boden i norr till Malmö i söder för att få ett personalperspektiv på situationen.

Det är också viktigt att få ett patient- och klientperspektiv. Vi har därför valt att se hur behoven ser ut hos de asylsökande genom en journalstudie (se förklaring nedan).

Genom samtal och dialog med och mellan lokala, regionala och nationella aktörer som arbetar med asylsökande/frågor kring asylsökandes situation kommer resultatet av studien att spridas och diskuteras och kunna ligga till grund för att förbättra hälsosituationen för asylsökande.

**1. Intervjun går till på följande sätt:**

- Det är helt frivilligt att delta i intervjun och intervjun börjar först efter att ett muntligt/skriftligt samtycke har givits av handläggaren/behandlaren. Den som intervjuas (respondenten) har full rätt att avbryta sin medverkan när som helst, utan att ange skäl.
- Medverkan i studien kommer att innebära att handläggare/behandlare träffar forskarstuderande (Stålgren) för en enskild intervju där respondenten ombeds att berätta fritt runt några frågor.
- Intervjun tar ungefär 30-60 minuter och den kommer efter medgivande att spelas in på en diktafon.
- Ljudinspelningen kommer att förvaras inlåst och endast vara tillgängliga för projektgruppen. All information kommer att vara anonym. Studiematerialet kommer att behandlas konfidentiellt och i det färdiga arbetet kommer man inte att kunna identifiera den person som blivit intervjuad. Insamlade data bevaras säkert så att inte obehöriga kan komma åt dem.
- Den som blir intervjuad kommer att få ta del av resultatet och då ha möjlighet att ge kommentarer och synpunkter på materialet före publicering.

**2. Journalformulärstudien går till på följande sätt:**

Handläggaren/behandlaren väljer slumpmässigt ut 3 journaler/akter, en man, en kvinna och ett barn (under 18 år) där han/hon det senaste året står som huvudansvarig och besvarar frågor från ett journalformulär (enkät) där frågorna berör patients/asylsökandes hälsa, samverkansformer, behov mm.

Inom en vecka kommer Maria Stålgren (MS) att höra av sig till dig för att höra efter om det finns några frågor. Därefter kommer MS att skicka ut ett brev till dina medarbetare med inbjudan att delta.

**Du är välkommen att kontakta oss:**

Projektledare och forskarstuderande: Maria Stålgren, leg.sjuksköterska

Projekt "Kartläggning, dialog för att främja hälsa hos asylsökande"

Svenska Röda Korset

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Huvudhandledare: Solvig Ekblad, docent, forskningsgruppleddare

Institutet för psykosocial medicin (IPM), docent och adj univ lektor vid Karolinska Institutet

Tel: 08-52482081

Bihandledare: Lars-Åke Persson, Professor i internationell barnhälsovård, Institutionen för kvinnors och barnhälsa, Internationell mödra- och barnhälsovård (IMCH), Uppsala Universitet., Tel: 018-611 92 94

28 maj 2007

**Till chef f6r Migrationsverkets mottagningsenhet**

Inbjudan till Migrationsverkets biståndshandläggare på mottagningsenheter som handhar sökande som bor i eget boende/anläggningsboende att delta i forskningsprojektet "Kartläggning och dialog för att främja asylsökandes hälsa".

Studien är granskad och godkänd av Regionala etikprövningsnämnden i Stockholm, diarienummer: 2007/206-31.

Projektet delfinansieras av Europeiska Flyktingfonden (ERF).

*Syftet med projektet är att främja hälsa för asylsökande.*

Det är viktigt att vi får kunskap om erfarenheter som finns hos den enskilda biståndshandläggaren/mottagningshandläggaren av asylärenden, för att främja hälsa hos asylsökande. Vi har därför valt att genomföra enskilda intervjuer med handläggare från Boden i norr till Malmö i söder för att få ett personalperspektiv på situationen.

I studien kartläggs bland annat vilka insatser Migrationsverket och Røda Korset gör, vilka behov de asylsökande har, vad andra aktörer gör, hur samverkan fungerar, identifiera goda exempel och finna vilka brister som finns.

Genom samtal och dialog med och mellan lokala, regionala och nationella aktörer som arbetar med asylsökande/frågor kring asylsökandes situation kommer resultatet av studien att spridas och diskuteras och kunna ligga till grund för att förbättra hälsosituationen för asylsökande.

**1. Intervjun går till på följande sätt:**

- Det är helt frivilligt att delta i intervjun och intervjun börjar först efter att ett muntligt/skriftligt samtycke har givits av handläggaren. Den som intervjuas (respondenten) har full rätt att avbryta sin medverkan när som helst, utan att ange skäl.
- Medverkan i studien kommer att innebära att handläggare träffar forskarstuderande (Stålgren) för en enskild intervju där respondenten ombeds att berätta fritt runt några frågor.
- Intervjun tar ungefär 30-60 minuter och den kommer efter medgivande att spelas in på en diktafon.
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- Den som blir intervjuad kommer att få ta del av resultatet och då ha möjlighet att ge kommentarer och synpunkter på materialet före publicering.

Inom en vecka kommer Maria Stålgren (MS) att höra av sig till dig för att höra efter om det finns några frågor. Därefter kommer MS att skicka ut ett brev till dina medarbetare med inbjudan att delta.

**Du är alltid välkommen att kontakta oss:**

Forskarstuderande och projektledare: Maria Stålgren, leg. sjuksköterska

Projekt "Kartläggning, dialog för att främja hälsa hos asylsökande"

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Huvudhandledare: Solvig Ekblad, docent, forskningsgruppledare

forskningsgruppledare

Migration och Hälsa, Stressforskningsinstitutet, docent och adj univ lektor vid Karolinska Institutett

Tel: 08-533 789 02

Bihandledare: Lars-Åke Persson, Professor i internationell barnhälsovård, Institutionen för kvinnors och barnhälsa, Internationell mödra- och barnhälsovård (IMCH), Uppsala Universitet., Tel: 018-611 92 94

Maj 2007

Med detta informationsblad vill vi inbjuda Dig att delta i forskningsprojektet "Kartläggning och dialog för att främja asylsökandes hälsa" Studien är granskad och godkänd av Regionala etikprövningsnämnden i Stockholm, diarienummer: 2007/206-31.

Studien delfinansieras av Europeiska Flyktingfonden.

Vi vill inbjuda dig som;

- arbetar med handläggning av asylärenden i Röda Korset
- arbetar vid Röda Korsets center för krigsskadade och torterade
- arbetar vid Röda Korset sjukvårdsförmedlingen för irreguljära migranter i Stockholm

**Syftet med projektet är att främja hälsa för asylsökande.**

I studien kartläggs bland annat vilka insatser Röda Korset och Migrationsverket gör, vilka behov de asylsökande har, vad andra aktörer gör, hur samverkan fungerar, goda exempel och vilka brister som finns.

Det är viktigt att vi får kunskap om dina erfarenheter av att handlägga asylärenden eller ge behandling. Vi har därför valt att genomföra enskilda intervjuer med handläggare/behandlare från Boden i norr till Malmö i söder för att få ett personalperspektiv på situationen.

Det är också viktigt att få ett patient- och klientperspektiv. Vi har därför valt att se hur behoven ser ut hos de asylsökande genom en journalstudie.

Genom samtal och dialog med och mellan lokala, regionala och nationella aktörer som arbetar med asylsökande/frågor kring asylsökandes situation kommer resultatet av studien att spridas och diskuteras och kunna ligga till grund för att förbättra hälsosituationen för asylsökande.

**1. Intervjun går till på följande sätt:**

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- Medverkan i studien kommer att innebära att Du träffar forskarstuderande (Maria Stålgren) för en enskild intervju där Du inbjuds att berätta fritt runt några frågor kring de asylsökandes situation.
- Intervjun tar ungefär 30-60 minuter och den kommer efter medgivande att spelas in på en diktafon.
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- Du kommer att få ta del av resultatet och ha möjlighet att ge kommentarer och synpunkter på materialet före publicering.

**2. Journalformulärstudien går till på följande sätt:**

Du väljer slumpmässigt ut 3 journaler/akter, en man, en kvinna och ett barn (under 18 år) där du det senaste året står som huvudansvarig och besvarar frågor från ett journalformulär (enkät) där frågorna berör patients/asylsökandes behov, hälsa, samverkansformer mm.

Inom en vecka kommer Maria Stålgren (MS) att höra av sig till dig för att höra efter om det finns några frågor, samt med en förfrågan om du tackar Ja till inbjudan.

**Du är välkommen att kontakta oss:**

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Migration och Hälsa, Stressforskningsinstitutet, docent och adj univ lektor vid Karolinska Institutet

Tel: 08-533 789 02

Bihandledare: Lars-Åke Persson, Professor i internationell barnhälsovård, Institutionen för kvinnors och barnhälsa, Internationell mödra- och barnhälsovård (IMCH), Uppsala, Tel: 018-611 92 94



December 2007

Med detta informationsblad vill vi inbjuda Dig att delta i forskningsprojektet "Kartläggning och dialog för att främja asylsökandes hälsa"

Vi vill inbjuda Dig som arbetar som Biståndshandläggare på Migrationsverkets mottagningsenheter som handlägger sökande som bor i eget boende/anläggningsboende.

Studien är granskad och godkänd av Regionala etikprövningsnämnden i Stockholm, diarienummer: 2007/206-31.

Studien delfinansieras av Europeiska Flyktingfonden.

*Syftet med projektet är att främja hälsa för asylsökande.*

I studien kartläggs bland annat vilka insatser Migrationsverket och Röda Korset gör, vilka behov de asylsökande har, vad andra aktörer gör, hur samverkan fungerar, goda exempel och vilka brister som finns.

Det är viktigt att vi får kunskap om dina erfarenheter av att handlägga asylärenden. Vi har därför valt att genomföra enskilda intervjuer med handläggare på de olika mottagningsenheterna/enheter som handlägger sökande som bor i eget boende/anläggningsboende från Boden i norr till Malmö i söder.

Genom samtal och dialog med och mellan lokala, regionala och nationella aktörer som arbetar med asylsökande/frågor kring asylsökandes situation kommer resultatet av studien att spridas och diskuteras och kunna ligga till grund för att förbättra hälsosituationen för asylsökande.

#### **1. Intervjun går till på följande sätt:**

- Det är helt frivilligt att delta i intervjun och intervjun börjar först efter att Du givit ett muntligt/skrifligt samtycke. Du har full rätt att avbryta din medverkan när som helst, utan att ange skäl.
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Inom en vecka kommer Maria Stålgren (MS) att höra av sig till dig för att höra efter om det finns några frågor, samt med en förfrågan om du tackar Ja till inbjudan.

#### **Du är välkommen att kontakta oss:**

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Projekt "Kartläggning, dialog för att främja hälsa hos asylsökande"

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Tel: 018-611 92 94

**Bakgrundsinformation om respondenten**

Hur många års arbete har du med asylsökande?

Har du andra erfarenheter med/som asylsökande, flyktingar/flyktingskap?

**Vad brukar de asylsökande fråga om som rör hälsa eller hälso- och sjukvård, ge ett exempel?**

**Vad är hälsa för dig?**

**Vad är sjukdom för dig?**

*Visa bilaga intervjuguide*

**Ge de 2 mest angelägna exemplen på situationer som påverkar den asylsökandes hälsa negativt?**

**Ge de 2 mest angelägna exemplen på situationer som påverkar den asylsökandes hälsa positivt?**

**Vad brukar du fråga om den asylsökandes hälsa?**

**Om det finns barn i familjen vilka frågor ställer du kring barnens situation?**

**Sonderingsfrågor – ”probings”**

- vad händer, berätta?
- vad gör du, ge ett exempel?
- vad tänker du?

- Boende
- Ekonomisk situation
- Organiserad sysselsättning/arbete/skola och barnomsorg
- Hälsobehov
- Speciella behov – handikapp, erfarit tortyr, svält

**Om den asylsökande mår sämre än förväntat vad gör du då inom ditt ansvarsområde?**

**Hur är tillgängligheten till vård för de asylsökande i din region?**

**Vad tolkar du in i begreppet ”vård som inte kan anstå”?**

**Hur har ni praktiskt ordnat tillgängligheten för er (handläggare/verksamhet för asylsökande under de senaste halvåret, ge exempel?**

**Är det någon förändring mot tidigare rutiner, i så fall vad?**

**För du någon statistik över några uppgifter, i så fall på vad?**

Rev 11 gjord efter intervju 23. Används från och med intervju 24. Reviderad 071119 1/2

**Vilka samverkar du med internt/extern?**

SAOL: arbeta l. utöva verksamhet tillsammans, gemensamt (med en l. flera andra personer l. grupper l. sammanslutningar (äv. dels: samordna l. ha samordnat sin verksamhet. arbeta efter en gemensam plan l. efter gemen samma grundlinjer) dels närmande sig bet.: stödja l. hjälpa varandra)

- när samverkar ni?

- om vad?

- och varför?

**På vilka sätt samverkar du med dina kollegor? Ge exempel.**

**Beskriv en situation där samverkan var nödvändig.**

**Vad är de viktigaste fördelarna/hindren med samverkan, ge exempel!**

**Finns det samverkan på chefsnivå, ge exempel?**

**Finns det någon situation där du önskar att du hade haft samverkan med andra aktörer, ge exempel?**

**Känner du till "Nationell samsyn kring hälsa och den första tiden i Sverige", (Integrationsverket 2004)?**

**FN:s specielle rapportör för bästa uppnåeliga hälsa påpekar att vårdutbildningarna i Sverige saknar utbildning i de mänskliga rättigheterna och hur de tillämpas, hur ser det ut för dig i din utbildning?**

**Vad har du för utbildning?**

**Vilket stöd får du för ditt arbete?Handledning? Utbildning?**

**Finns det något mer som du vill tillägga som jag inte frågat om?**

**Sonderingsfrågor – "probings"**

- vad händer, berätta?

- vad gör du, ge exempel?

- vad tänker du?

**Bakgrundsinformation om respondenten**

Ålder?

Kön: man

kvinna

**OBSERVATION:**

Finns handfat på rummet?

JA

NEJ

Finns tvål?

JA

NEJ

Finns pappershanddukar?

JA

NEJ

Finns handsprit?

JA

NEJ

Rev 11 gjord efter intervju 23. Används från och med intervju 24. Reviderad 071119 2/2