UMEÅ UNIVERSITY

Health assessments of asylum seekers within the Swedish healthcare system

A study of the interface between control and care, and how structure and procedures may influence access and coverage

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In memory of my mother.
A bright mind and divine wings,
but denied to fly.

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Abstract

Background
Despite lack of evidence, there is a common notion that diseases are brought along with migrants, and thus a threat to people in the host country. In Sweden asylum seekers are to be offered a health assessment (HA), but national statistics show that the coverage is less than 50%. It has been assumed that asylum seekers do not want to attend, but this research data instead indicate structural barriers.

Objectives
To explore to what extent the Swedish healthcare system provides optimal conditions for asylum seekers to access the HA and how the HA could meet their own perceived health needs, as well as society's demand on detecting contagious diseases, from a public health perspective.

Methods
This research project adopted a mixed method approach. A quantitative cross-sectional design was applied where different questionnaires were used, targeting administrators and healthcare professionals as well as former asylum seekers. In addition a qualitative, interpretative and descriptive research approach was applied, guided by grounded theory. Individual interviews were carried out among former asylum seekers.

Results
This research revealed that there is no coherent national system for the HAs on asylum seekers in Sweden. The structures, organizations, procedures and outcomes vary significantly between the 21 counties, and the reasons for the low coverage seemed multifold. The former asylum seekers stated feelings of ambiguity and mistrust due to lack of information on the purpose of the HA and how it might influence their asylum application. Poor communication was identified as one of several barriers to access healthcare. The attitude was positive to the HA as such, but it was considered to be just a communicable disease control, without focus on their own perceived health needs, thus an imbalance between control and care.

Conclusions
Although being an important contribution, the HA does not suffice to fulfill the right to health of asylum seekers, due to shortcomings regarding accessibility and acceptability of the information, procedures and services that it includes.

Keywords
Public health, migration, asylum seekers, health system, health assessment, control and care, Sweden

Sammanfattning på svenska

Bakgrund
Trots avsaknad av fakta så finns en föreställning om att migranter för med sig sjukdomar som utgör ett hot för personer i värdlandet. I Sverige ska asylsökande erbjudas en hälsoundersökning (HU), men nationell statistik visar på en genomförandegrad av mindre än 50 procent. Det har antagits att asylsökande inte vill delta, men resultat från denna forskning indikerar istället på strukturella hinder.

Syfte
Att utforska i vilken utsträckning det svenska hälsosystemet erbjuder optimala förutsättningar till asylsökande att få tillgång till en HU och hur HU kan möta den asylsökandes upplevda hälsobehov, liksom kravet på att upptäcka smittsamma sjukdomar, utifrån ett folkhälsoperspektiv.

Metod:
I detta forskningsprojekt har olika forskningsmetoder använts. En kvantitativ tvärsnittsdesign tillämpades där olika frågeformulär användes till administratörer och vårdpersonal samt till före detta asylsökande. Vidare användes en kvalitativ design med tolkande och beskrivande forskningsansats enligt ”grounded theory”. Individuella intervjuer genomfördes bland före detta asylsökande.

Resultat:
Forskningsresultaten visar på avsaknad av ett sammanhängande nationellt system för genomförande av HU av asylsökande i Sverige. Struktur, rutiner, uppföljning och resultat varierar avsevärt mellan de 21 landstingen, och skälen till den låga genomförandegraden förefaller vara mångsidig. Deltagarna uttryckte ambivalens och misstro eftersom de saknade information om syftet med HU och hur resultatet skulle kunna påverka deras asylansökan. Bristfällig kommunikation visade sig vara ett av flera hinder för att ta del av vård. Att bli erbjuden en HU uppfattades positivt, men fokus sades bara var på smittsamma sjukdomar och inte på den ohälsa man själv upplevde. Således fanns en obalans mellan kontroll av smittor och upplevda vårdbehov.

Slutsatser:
Även om HU ansågs betydelsefull, visar resultaten på att den inte påtagligt bidrar till att förverkliga asylsökandes rätt till hälsa, på grund av hinder och bristande tillgänglighet och acceptans av information och genomförandet av HU.

Nyckelord:
folkhälsa, migration, asylsökande, hälsosystem, hälsoundersökning, kontroll och vård, Sverige

Concepts and definitions

Asylum: A form of protection given by a State on its territory based on internationally or nationally recognized refugee rights. It is granted to a person who is unable to seek protection in his or her country of nationality and/or residence in particular for fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion (1).

Asylum seeker: A person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds (1).

Care that cannot be postponed: According to the *Law on health care for asylum seekers and others* (2), besides the HA, asylum seekers are entitled to *care that cannot be postponed*. A challenging and somewhat tense debate started on how to interpret or apply this concept within clinical practice in Sweden. In 2013 the National Board of Health and Welfare (NBHW) was assigned by the Ministry of Health to come forward on a definition for the same. NBHW have then stated that the term is inconsistent with medical professional ethics, is not medically applicable in healthcare and risks endangering patient safety. Only physicians or other healthcare professionals who have knowledge of the patient's individual circumstances can assess what measures are required and when (3).

Circular migration: The fluid movement of people between countries, including temporary or long-term movement which may be beneficial to all involved, if occurring voluntarily and linked to the labor needs of countries of origin and destination (1).

Citizenship (also *nationality*): the status by which a person has full rights and responsibilities in a country, either as a result of being born there or by having acquired it through the legal immigration and citizenship process (i.e. naturalization). International migrants who became naturalized and did not give up their former citizenship are said to have 'dual citizenship' and frequently hold two passports (4).

Convention (also *treaty*): "An international agreement concluded between States in written form and governed by international law, whether embodied in a

single instrument or in two or more related instruments and whatever its particular designation" (*Art. 2.1(a) Vienna Convention on the Law of Treaties, 1969*) (1).

Country of destination (also *host country* and *receiving country*): The country that is a destination for migratory flows, regular or irregular (1).

Country of origin: The country that is a source of migratory flows, regular or irregular (1).

Coverage: In this context, the number of asylum seekers that undergo the health assessment in relation to the total number of asylum seekers.

Culture: Term used to describe the symbolic organization of a social group, the values that the group chooses for itself in its relations with other groups. It may also refer to the aggregation of customs, beliefs, language, ideas, aesthetic tastes, technical knowledge, value systems and lifestyles (1).

Discrimination: A failure to treat all persons equally where no objective and reasonable distinction can be found between those favored and those not favored. Discrimination is prohibited in respect of "race, sex, language or religion" (*Art. 1(3), UN Charter, 1945*) or "of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (*Art. 2, Universal Declaration of Human Rights, 1948*) (1).

Equity (also ***e**quality*): Equal rights and opportunities for all human beings (5).

Family reunification: Process whereby family members separated through forced or voluntary migration regroup in a country other than the one of their origin (1).

Forced migration: A migratory movement in which an element of coercion exists, including threats to life and livelihood, whether arising from natural or man-made causes (1).

Foreign background: A person who is foreign born, or born in Sweden and having two foreign-born parents (Statistic Sweden, scb.se).

Grounds of discrimination: Equal rights and opportunities irrespective of sex, transgender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age pursuant to the Discrimination Act (2008:567) (6).

Health: According to the preamble of the World Health Organization Constitution (1946), health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (7).

Health assessment (also *health examination and health screening*)**:** In the migration context, the function of reducing and better managing the public health impact of population mobility on receiving countries as well as to facilitating the integration of migrants through the detection and cost-effective management of health conditions and medical documentation. Pre-departure health assessments offer an opportunity to promote the health of assisted migrants in providing an occasion to initiate preventive and curative interventions for conditions that, if left untreated, could have a negative impact on the migrants' health status and/or public health of the host communities (1).

In this research one of the key concept is Health assessment (HA), corresponding to the Swedish word *hälsoundersökning*, referred to in the *Law on health care for asylum seekers and others* (2). NBHW has in an instruction (SOSFS 2011:11) clarified the purpose of the health assessment and how it should be applied (8).

Health literacy: The degree to which individuals can obtain, process, understand, and communicate about health-related information needed to make informed health decisions (9).

Human rights: Those liberties and benefits based on human dignity which, by accepted contemporary values, all human beings should be able to claim "as of right" in the society in which they live. These rights are contained in the *International Bill of Rights*, comprising the *Universal Declaration of Human Rights, 1948,* the *International Covenant on Economic, Social and Cultural Rights,* and *the International Covenant on Civil and Political Rights, 1966* and have been developed by other treaties from this core (1, 10).

Illegal migrant (See Irregular migrant)

Irregular migrant (also *undocumented migrant*): A person who, owing to unauthorized entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in a transit or host country. The definition covers inter alia those persons who have entered a transit or host country lawfully but have stayed for a longer period than authorized or subsequently taken up unauthorized employment (also called clandestine/undocumented migrant or migrant in an irregular situation). The term "irregular" is preferable to "illegal" because the latter carries a criminal connotation and is seen as denying migrants' humanity (1).

Family reunification: Family reunification applies to those who obtain a resident permit due to that other family member(s) already have received resident permit and live in Sweden (1).

Migrant: At the international level, no universally accepted definition for "migrant" exists. The term migrant was usually understood to cover all cases where the decision to migrate was taken freely by the individual concerned for reasons of "personal convenience" and without intervention of an external compelling factor; it therefore applied to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family (1).

Minor (also *child*): A person who, according to the law of the relevant country, is under the age of majority, i.e. is not yet entitled to exercise certain civil and political rights (1).

Public Health: Public health promotes and protects the health of people and the communities where they live. While doctors treat sick people individually, public health professionals work on preventing people from getting sick or injured and promote healthy behaviors (11).

Person with a foreign background: A person born outside Sweden or born in Sweden with parents born outside Sweden (Statistics Sweden. www.scb.se).

Quota refugee: A quantitative restriction in the migration or asylum context. Many countries establish quotas, or caps, on the number of migrants to be admitted each year (1).

Receiving country (also *country of destination* and *host country*): In the case of return or repatriation, also the country of origin. Country that has accepted to receive a certain number of refugees and migrants on a yearly basis by presidential, ministerial or parliamentary decision (1).

Refugee: A person who, "owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, 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 (1).

Regular migration: Migration that occurs through recognized, authorized channels (1).

Residence permit: A document issued by the competent authorities of a State to a non-national, confirming that he or she has the right to live in the State concerned during the period of validity of the permit (1).

The social determinants of health: (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life (12).

Unaccompanied child or minor: Person under the age of majority in a country other than that of their nationality who are not accompanied by a parent, guardian, or other adult who by law or custom is responsible for them (1).

Universal Health Coverage: Securing access to a certain health services or intervention at an affordable cost. Incorporates two complementary dimensions in addition to financial protection, e.g. who is covered and the extent of health service coverage (13).

Acronyms

AAAQ	availability, accessibility, acceptability and quality
AIDS	Acquired Immune Deficiency Syndrome
ABO	Swedish: Anläggnings BOende. English: Collective living
CD	Communicable Diseases
CEAS	Common European Asylum System
CESCR	The UN's Committee on Economic, Social and Cultural Rights
CSDH	Commission on Social Determinants of Health
EBO	Swedish: Eget BOende. English: Independent private living
ECDC	The European Centre for Disease Prevention and Control
ERF	European Refugee Fund
EU	European Union
EUPHA	the European Public Health Association
GP	General Practitioner
HA	Health assessment
HIV	Human Immunodeficiency Virus
HLV	Hälsa på lika villkor (Health on equal terms)
IOM	International Organization of Migration
NBHW	The National Board of Health and Welfare
NCD	Non - Communicable Diseases
PLHIV	People living with HIV
SALAR	Swedish Association of Local Authorities and Regions
SDG	Sustainable Development Goals
SDH	Social determinants of health
SMI	Swedish Institute for Communicable Disease Control
SRHR	Sexual and Reproductive Health and Rights.

STI	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nation High Commission on Refugees
WHO	The World Health Organization

List of publications

The thesis is based on the following original papers:

I. **Jonzon, R**., Lindkvist, P., Hurtig, A-K. Structural barriers to health assessments for migrants? An explorative survey in Sweden. BMC Health Services Research 2018 18:813.

II. **Jonzon R**., Lindkvist P., Johansson E. A state of limbo – In transition between two contexts. Health assessments upon arrival in Sweden as perceived by former Eritrean asylum seekers. Scandinavian Journal of Public Health. 2015; 43(5):548-558.

III. Lobo Pacheco L., **Jonzon R**., Hurtig A-K. Health assessment and the Right to Health in Sweden. Asylum seekers' perspectives. PLoS One. 2016; 11(9):e0161842.

Prologue and point of departure

There is to me a strong link between what I experienced back in the 1980th, early on my professional journey, and this thesis.

As a young nurse anesthetist I came to live and work in Nepal, at the time when the small, remote and poor Himalayan country just recently had opened up its closed passed towards the world around.

To me, at that time, it was a deep and honest desire – may be naïve - of contributing to a better world by serving the less fortuned Nepali people, by sharing my professional knowledge and experience. To some extent that came true, but moreover, I was the one who benefited and learned immensely from my Nepali counterparts, about life and vital necessities, culture and a "local" view of health issues, cause of disease and cure. Moreover, but not least, I learned how to carry out my anesthetic duties, lacking what I considered a prerequisite and necessity in anesthetic work, that until then I had taken for granted - oxygen!

It was during these years I gradually and unavoidably, in a deeper sense, came to realize the unfair division of wealth and health on our globe, and that "aid", "relief" and "charity" is good and necessary, but not enough, and different to equity and justice.

Back in Sweden, after almost six years in Nepal, it was as if anesthesiology had lost its attraction to me and I began studies in sociology and political science. Most important though, thoughts on culture in relation to health later brought me into studies of medical anthropology (14, 15), where I wrote my BA essay on HIV (Human Immunodeficiency Virus) in Nepal. Moreover, it equipped me with tools of concepts and perspectives that helped me sort out and in depth apprehend what I had experienced during the years in Nepal. I felt a need to reconsider my own "native" understanding of western thoughts in relation to health, disease, treatment and health systems. As a discipline, cultural anthropology assumes that study of culture is the study of difference or otherness (16). The scientific goal of cultural anthropology is understanding the different ways societies of the world have gone about the business of being human. The humanistic goal is entering on the journey to the self, by way of the detour of the other (17). I later learned that this is considered to be a cornerstone in social anthropology.

It was also in Nepal that I came to realize that the broader and most prevalent burden of disease and ill-health are not primarily to be tackled in the operating rooms in hospitals, since it had to do with poverty, social issues, knowledge, health literacy, water and sanitation etc. (18). That insight brought me into the

field of public health, which in fact also has a clear and interesting interface to anthropology. I had my Master in Public Health (MPH)-studies at the former Nordic School of Public Health (NHV) in Gothenburg, where my thesis came to be on Intimate partner violence, in Vietnam (19). NHV, what that amazing public health school have meant to me, personally and academically, would need a chapter of its own to tell.

In 2007 I was offered a position in a public health setting, in the unit for national co-ordination of HIV-prevention at the National Board of Health and Welfare (NBHW) in Stockholm. More precisely, I was assigned to work on one of the three major targets in the National strategy on HIV-prevention, that was launched the previous year (20):

> "HIV infection, in asylum-seekers and newly arrived immigrants that had come on family re-unification grounds, must be identified *within two months*, and within six months for other groups of people who have lived in high endemic areas."

The same strategy pointed out healthcare as a most important arena to detect HIV in migrants, particularly in connection with the health assessment (HA) that newly arrived migrants were to be offered.

How come, "They don´t come"?

In association with NBHW's evaluation of the regional accomplishments on HIV-prevention, I came to visit primary healthcare centers, in all 21 Swedish counties, between year 2007 and 2010. The purpose was to have a dialogue with the healthcare personnel on asylum seekers' HAs, including HIV-tests, in order to get a preliminary understanding on how the regions contributed to achieve the second target of the National HIV-strategy, namely early detection of HIV.

The picture that emerged was that this part of the health system, dealing with migrants, had a low status, less prioritized and functioning primarily due to committed nurse practitioners and GPs. The narratives I learned were feelings of professional solitude and isolation in carrying out their duties on migrants. Many complained that the asylum seekers did not turn up for the HA. Like a mantra, I heard the healthcare personnel saying, - They don't come. The way it was said and presented to me made me interpret it as, they don't want to come. Similarly, when I asked, why is that? They replied, - We don't know. No comments were made on that it might be structural shortcomings of some kind that contributed to the low coverage. Finally, when I searched for earlier investigations on how the asylum seekers' themselves might view the HA, in a belief that their view might be crucial, there was nothing to find.

How come, no one seemed to care?

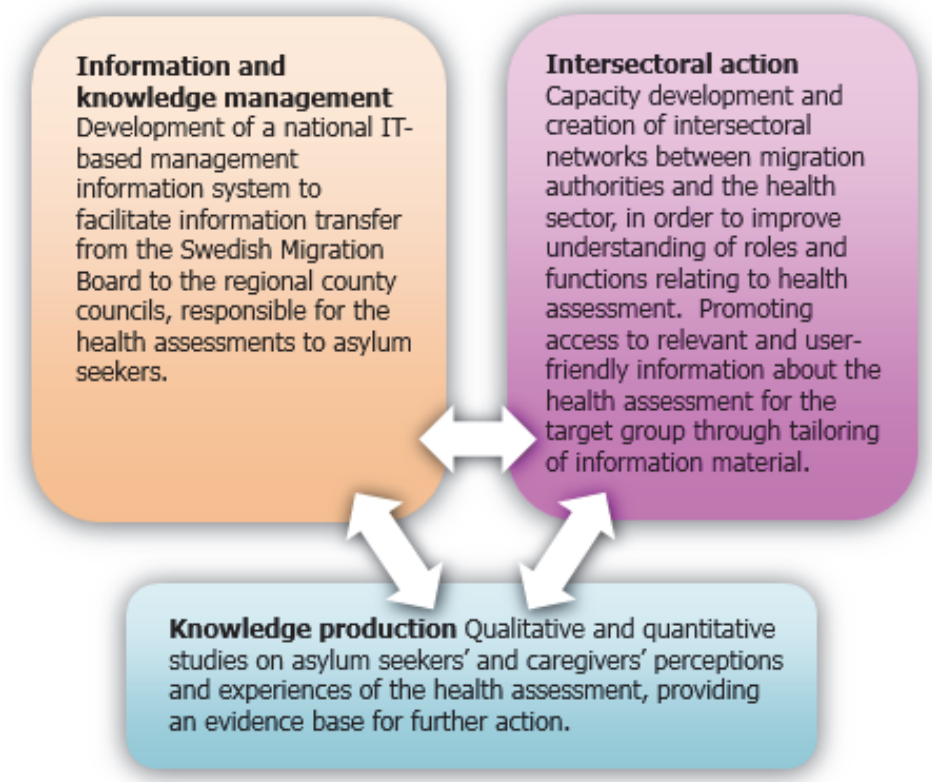
For a number of years national statistics had shown an average of less than 50 percent coverage on asylum seekers initial HA. Despite this fact, at that point, no particular actions had been taken to improve the situation, not from Government agencies, nor from the healthcare sector. I had come to the insight of societal shortcomings on this issue and a question that searched its answer was growing within me; How come, no one seemed to care?

It was not time to wait for someone else to act, but instead recognize the challenge and take the lead towards a change. After having had a multi-sectoral and multi-professional workshop and identified preliminary answers to the two crucial questions, namely: "What is the problem?" and "How to solve it?" I came to realize that this mission was far too great to be accomplished by myself or even the unit were I was working. It had to be a multi-sectoral co-operation of significant stakeholders, where each one is doing its part in order to succeed, similar to what is needed to many other public health interventions.

"Improved structure and coordination on health assessments of asylum seekers" was the title of a project that was launched in 2012 and running to mid-2014. It had financial support from the European Refugee Fund (ERF) and from the former Swedish Institute for Communicable Disease Control (SMI) and present Public Health Agency of Sweden.

The project consisted of three interconnected components, all contributing to the main goal: *Improving access and participation in health assessments through systematic change, knowledge production and intersectoral action*, as described in Figure 1.

Figure 1. An illustration of the three interconnected components (sub-projects) of the project; Improved structure and coordination on health assessments of asylum seekers



The sub-project, Knowledge production, aimed at first and foremost capture the asylum seekers' own perceptions and experiences of the HA (21-23) but also the caregivers' view on the issue (24).

At the planning stage for this thesis, it happened that I was questioned whether my research focus really was the best one. I was told that morbidity and epidemiology, not least HIV in relation to migrant populations would be a more relevant research focus. I did agree and still do, that is important, but if asylum seekers to a large extent do not turn up for the HA that they are entitled to, despite their self-reported health problems and that health authorities and politicians, by laws and regulations, postulate the importance of the HA, I was and still am convinced that it is on issues related to coverage and access to health service we have to begin. No matter how sophisticated healthcare, disease-programs and skilled personnel there are, if the target group for the HA, often in need of these healthcare services, do not find their way or lack access to the same (25).

After almost having completed my thesis, I recently and unexpectedly had a kind of reconfirmation on that the rational for this research project was right, after all. At times, I have had to defend my choice of research focus, but was happy to read some few words by the internationally recognized scholar on Migration Health Research, Dr Kevin Pottie, Associate Professor, Departments of Family Medicine and Epidemiology and Community Medicine, University of Ottawa; "… we often prepare atlases for care delivery of cardiac care and other diseases but we rarely look at the uptake of care for vulnerable populations."

Background

In this background chapter I intend to highlight some crucial features and phenomenon that hopefully will favor the comprehension of this research and its core issues.

I start out with *Migration and migration policy*. It is a vast topic that will have to be funneled down to and focus on migration to Europe and Sweden in particular in recent time.

The next section is on *global and regional public health policy* followed by a section on *national public health policy*. There are well known agencies such as United Nations, the World Health Organization and International Organization for Migration playing an important role on the international scene, setting objectives on global public health issues in relation to migration. This in turn will have an impact on the national level where ratified treaties are to be implemented and national policies produced to support the same, but adjusted and taken into account national and local preconditions.

Stemming from the previous sections, *Public health and Migration* will then be presented as an important intersection, and necessary to comprehend in the view of this thesis.

There is a growing body of evidence that migration under certain conditions, such as forced migration due to war or when people are threatened and have to leave due to political unrest, will jeopardize the health of migrants. Under the heading *Illness and burden of disease in migrant populations*, I will outline some of the knowledge on the topic as to date.

The section, *The Swedish healthcare system and policy on access*, will primarily focus on that part of the healthcare system where most migrants have their first contact, namely the primary healthcare sector and its clinics. The final part, *Health assessments* is closely linked to the previous part on the primary healthcare, since it is where the actual health assessment are carried out.

Migration and migration policy

Migration globally

Human migration is not a new phenomenon (26). Mobility has been a characteristic of mankind since early time of human history. Commonly it has been a less dramatic occurrence, rather something that always has been there, silently and

gradually ongoing, in most parts of the world. In the modern era migration provide states, societies and migrants with many opportunities. The vast majority of people migrate internationally for reasons related to work, family and study. However, at times migration has had a more dramatic evolution, sprung from armed conflicts, oppressions, natural catastrophes such as floods, draughts that in turn may have led to famine. Even if displaced people such as asylum seekers and refugees comprise a relatively small proportion of all international migrants, they are for most part in highly vulnerable situations that demand attention of different kinds, among them healthcare (27).

The Uprooted, the title of an epic story of the great migrations that made the American people, by Oscar Handlin, was published in 1951 (28). It is said to be one of the most influential books ever published in the field of migration. The writer captures the core of the experience of millions of Europeans who made their way to America in the century after 1820, escaping poverty, shortage of food and religious oppression. The story told is human-centered, and communicate what groups of peoples, such as eastern Europeans, Jews, Scandinavians and others, experienced in common. There are many similarities between what is written about in The Uprooted, and what people experiencing today, 200 years later, arriving in Sweden, Europe and elsewhere, from various parts of the world, in search for security and a better life.

In 2018, the entire global population reached 7.6 billion people. Of these, 1 in every 30 persons or 258 million were international migrants, 52% male and 48% female, living in a country other than their country of birth. This is an increase of 49% since 2000, i.e. in only 18 years. Out of the total 258 million international migrants almost 10%, or 26 million, were asylum seekers or refugees. Of these, 51% were minors under the age of 18, and many unaccompanied (29).

By the end of 2017, about 3.1 million people worldwide were awaiting a decision on their application for asylum, about half of them in developing regions (30). Although a majority of the world's international migrants live in high-income countries, low- and middle-income countries host nearly 22 million, or 84%, of all refugees and asylum seekers (29).

Looking back, there was a strong call for international action after the Second World War, similar to what we can experience and see now in the present migration crises in Europe and elsewhere. At that time, the global community by means of the UN-system created the United Nations High Commissioner for Refugees (UNHCR). In its Statute of 1950 UNHCR's central responsibilities of international protection is outlined. Specifically, the Statute provides that the High Commissioner '*acting under the authority of the General Assembly, shall assume the*

function of providing international protection ... and of seeking permanent solutions for the problem of refugees (31). To what degree "permanent solutions for the problem of refugees" has been accomplished can be argued about. However, this UNHCR Statute launched almost 70 years ago can definitely be seen as an important cornerstone and foundation of establishing a global governance of forced migration. Ever since then, there have been efforts to improve the global governance of migration, building on the norms and institutions developed in the past.

Migration to Europe

The first most important regulation on migration at EU-level was the 1990 Dublin Convention which came into force on 1 September 1997, establishes a system determining the state responsible for examining the applications for asylum lodged in one of the Member States of the European communities (32). The underpinning of the so called Dublin system is the principle of authorization, under which the State which has "authorized" the entry of an asylum seeker on the territory of the Member State is responsible for examining his or her application. In 2003 a "Dublin II"-regulation was launched to establish the principle that only one Member State should be responsible for examining an asylum application (33). The objective was to avoid asylum seekers from being sent from one country to another, and also to prevent abuse of the system by the submission of several applications for asylum by one person. There has been and still is critiques on the Dublin-convention, mainly due to a perception of it as representing the construction of a European fortress (34, 35).

In year 2015 almost one third of the world's international migrants (75 million) lived in Europe. Over half of these (40 million) were born in Europe, but were living elsewhere in the region, which has increased from 27 million in 1990. The population of non- European migrants in Europe reached over 35 million in 2015 (27). Among those migrants, close to 1.4 million applied for asylum within the EU the same year and 32% of them were minors. The largest groups of asylum seekers came from Syria, Afghanistan, Iraq and Pakistan (36). This almost epic entry of large numbers of refugees and asylum seekers to Europe, the many lives that had been vanished while on escape on land and sea and the obvious shortcomings of the EU to manage the situation became a reminder of the urgent need to accomplish a Common European Asylum System (CEAS) that the EU has been working on since 1999 (37). In addition, this has increasingly led to a call for stronger international governance of migration. A recent attempt was in 2016 when the United Nations General Assembly committed to start a process of intergovernmental negotiations, leading to the adoption of a global compact for safe, regular

and orderly migration. The negotiated outcome is the *2016 New York Declaration for Refugees and Migrants* ("New York Declaration") (38), which was adopted in 2018 (39).

Migration to Sweden

There is documentation on that migration to Sweden took place already in the middle ages, but in the following outline the focus will be on immigration to Sweden since World War II. During the war in the 1940s and into the 1950s refugees from Germany, the neighboring Nordic countries and the Baltics sought for a safe haven in Sweden. After the war many returned while some, mainly refugees from the Baltic countries, remained in Sweden (40).

In the 1950s and 1960s Sweden were short of work force and a growing number of labor immigrants found their way to Sweden, mainly from other Scandinavian countries, Italy, Greece, Yugoslavia and Turkey. At the end of the 1960s, regulated immigration was introduced which in the 1970s resulted in a reduction of non-Nordic labor immigrants. Instead the Nordic, and in particular the Finnish, immigration increased drastically over some years. Not only labor immigrants came in the 1970s, as refugees also came intermittently, most often in direct connection to armed conflict or crises, such as the 1973 military coup in Chile (40).

The 1980s came to be the decade when asylum seekers began to arrive in Sweden in a steadily growing numbers, from around 12000 in year 1984 to more than 84000 in 1992 (41). Initially people escaped from war and oppression in Iran, Iraq, Lebanon, Syria, Turkey and Eritrea, not only to Sweden but all over Western Europe, but towards the end of the 1980s asylum seekers also started arriving from Somalia, the Balkans and several of the former Eastern Bloc countries, as a mirror to the crises in these nations at that time (41).

In accordance with the change of labor immigrants to asylum seekers and refugees in the 1980s, a new system for the reception of migrants was introduced. The responsibility was handed over from the labor market authorities to the Swedish Immigration Board, the predecessor of the present Swedish Migration Agency (40).

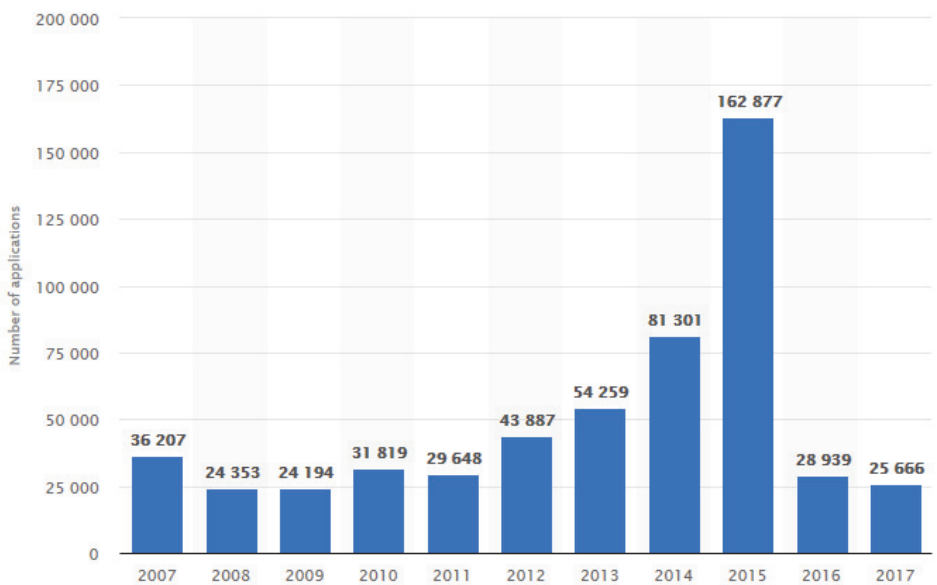
Between year 1995 and 1999, the number of asylum seekers to Sweden was fairly low but rose again thereafter and has been high ever since, with the exception of few temporary dips (41).

In the 2000s increasingly asylum seekers arrived to Sweden without identification and travel documents, which caused longer and more complicated asylum

processes. It also became a hindrance to implementing the refusal-of-entry decisions that to a larger extent were made. The number of people with decisions for refusal-of-entry increased, but they could not be forced to return In the same decade the number of unaccompanied minors seeking asylum increased dramatically during this time, from around 400 per year to several thousands, which put a great deal of strain on the municipalities which in 2006 took over the responsibility for accommodating unaccompanied minors from the Migration Agency (40).

In the first half of the 2010s the number asylum applicants to Sweden increased dramatically. Among the 162 877 asylum seekers that arrived in 2015, close to 30 % came from war-torn Syria (41). (Figure 2)

Figure 2. Number of asylum applications in Sweden from 2007 to 2017



Source: Migration Agency Sweden

With an aim to reduce the number asylum seekers, the same year Sweden introduced temporary border controls and other policy restrictions. In 2016 Sweden goes from having the EU's most generous asylum laws to the minimum EU level (42). This increase of asylum seekers was not limited to Sweden, but rather a pan-European phenomena that started massive political tension and debate in Sweden, as in the entire EU. The non-compliance to the Dublin-regulation was a disturbing fact to many EU member states (32). Among them was Sweden.

Global and regional public health policy

A cornerstone in the creation of a more just global healthcare was lay down forty years ago, in 1978, in Alma-Ata, former USSR, what later came to be Almaty, Kazakhstan. In the International Conference on Primary Health Care, organized by the World Health Organization (WHO) , the Declaration on Primary Health Care, "the Alma-Ata Declaration", was adopted (43). It had a strong and clear, message, on the interconnected and mutually reinforcing entities that human rights and public health encompasses. The Declaration provided a global strategy for primary health care, linked with the WHO- strategy "Health for All". The emphasize on Primary Healthcare as the foundation to all healthcare became a change from vertical hospital-based technologies to horizontal public health systems with recognition of the social determinants of health (18). In the context of this research project where migrants' and particularly asylum seekers' reduced access to healthcare is at focus, it appears clear that there is still more to do before declarations and polices written in a spirit of humanism, are applied into practice.

Despite these conventions and declarations the gap between social strata in relation to health continued to grow wider, which caused WHO in 2005 to establish the Commission on Social Determinants of Health (CSDH). The Commission aimed at addressing the social factors leading to ill health and health inequities and in creating better social conditions for health, particularly among the most vulnerable people. The commission's report, "Closing the gap in a generation" and sometimes referred to as "the Marmot Commission report" is another cornerstone in the attempt to create health equities (44). While asylum seekers are waiting to be able to "enjoy the highest attainable standard of physical and mental health" by equal access to primary healthcare, they most certainly will benefit from any interventions that aim to reduce social factors leading to ill health and health inequities.

Similar to what is described above on the necessity of migration policy, Global Public Health, at times labelled International Public Health, stem from a notion that various important health related issues are "borderless" and need to be tackled in collaboration between countries at different levels. This in turn will have an impact on the national level where international ratified treaties are to be implemented and regional and national policies produced to support the same, but adjusted and taken into account regional, national and local preconditions. The ongoing globalization bring people closer to each other across national and geographical borders that create new challenges as well as opportunities with significant bearings on public health and public health policy.

Public health policy and interventions, whether it is on international or local level, have to be based on evidence. Like never before, globalization and modern technologies has given excellent preconditions to share access to knowledge, skills and resources across the globe.

The most prominent and influential performer on the international public health arena is probably the World Health Organization (WHO) (45). Still, there is no truly centralized global public health system. In a "shrinking" world the need for world governing bodies is likely to grow, also in the public health field. As for WHO, it also play an important role in public health on a regional level, such as Europe (46). Besides WHO, there are other examples of bodies of importance and initiative taken to serve the global public health community and authorities with easily accessible data and evidence on issues such as global burden of disease, in order to more accurately propose and launch international public health policies (47). At European regional level there are other important public health actors such as the EU with its Commission (48) and expert agencies such as the European Centre for Disease Prevention and Control (ECDC) (49).

According to Article 13 of the Reception Conditions Directive, EU Member States may require health screenings for applicants for international protection on public health grounds. There is, however, no obligation to undertake such screenings.

National public health policy

The overall goal of public health policy is to create social conditions for good health on equal terms for the entire population. This applies to both communicable diseases (CD) and non - communicable diseases (NCD) and beyond, since health is not just the absence of disease or infirmity but a state of complete physical, mental and social well-being (25).

Public health policy, whether international or national, is basically the same thing. It is just a matter of geography and complexity. National public health policy reflects international public health policy, since it is at national level international treaties are to be implemented and national policies formed to support the same, though adjusted to local conditions.

In the aftermath of the AIDS - (Acquired Immune Deficiency Syndrome) pandemic, since 1996, the United Nations General Assembly Special Sessions on HIV/AIDS (UNAIDS) has led and inspired global, regional, national and local leadership, innovation and partnership to end AIDS as a public health threat and ultimately consign HIV to history (50). The Swedish national strategy to combat HIV/AIDS and certain other communicable diseases was launched in 2006 (20).

The strategy highlighted risk groups in need for special attention in HIV-preventive interventions and early detection of HIV. “Persons with a foreign origin”, in a recent updated version of the strategy labelled “migrants”, was highlighted as one of those most prioritized groups.

Closely linked to the National Strategy to combat HIV/AIDS and certain other communicable diseases is the Swedish Communicable Diseases Act (2004:168) since HIV, like other infectious diseases such as tuberculosis and hepatitis are all covered by the law (51). It states that testing and treatment are free of charge for residents in Sweden and for those who are covered by EU regulation 883/2004. In 2013 a new law was launched which granted the same access to healthcare for undocumented migrants as asylum seekers. Thus, undocumented migrants also have access to testing and treatment free of charge (52).

In 2018 the Swedish Government presented a new public health policy entitled “Good and equitable public health – an advanced public health policy”. Its focus is on equity and health, and emphasize that all sectors in society should attempt to reduce the unequal opportunities for good and equitable public health in the population (53). This is an example of how international policies and strategies are implemented on a national level.

Public health and migration

As the world is “shrinking” through globalization and that people increasingly, for various reasons, move across national borders, Public health have gradually become a matter of global concern. In the past, and still, authorities have for most part been concerned with contagious diseases being transferred by people from the outside world into a nation’s territory and its citizens. Based on data from ECDC (54), WHO (55) and the Public Health Agency of Sweden, an assessment was made of whether the influx of refugees poses a risk of spreading infectious diseases to the host population. The overall risk was, on a scale from very low to extremely high, assessed to be low for all relevant diseases such as Tuberculosis, HIV, Hepatitis B and C, Measles, Polio, Diphtheria and Typhoid (56). Even so, the risk to get infected is there, but to a greater extent for the migrants than for the host population. Among migrants originating from countries where serious infections such as tuberculosis, hepatitis A and B and HIV is common, they are more likely to have been exposed to such agents. Even after having received a residence permit and settled in the host-country, many return to their country of origin for visits and may again be susceptible to these agents. Independently on where a person have come from and where a person live there are other issues such as whether the person is vaccinated or not against health threatening agents that may be crucial to remain healthy.

To focus only on communicable diseases (CD) is a too narrow view of public health threats in relation to mobility and migration. Non-communicable diseases (NCD) are more likely a much bigger public health threat in relation to migration. Among these, mental health sufferings is significantly present (57). The social determinants of health threats and health inequalities is significantly important to consider when exploring public health in relation to migration (18). Migrants commonly face health threats from both CD and NCD associated with pre-migration living conditions, circumstances and experiences during the actual migration period as well as living conditions in the host-country. Not all, but many, end up in deprived neighborhoods, lacking job and thus sufficient economy, low health literacy, exposed to drugs and violence. Finally, lack of access or decimation of healthcare that migrants may face is not least also a public health issue in relation to migration.

Illness and burden of disease in migrant populations

Migrants as a category is problematic since there is no common reconized definition of the same and that "migrants" comprize a number of sub-categories that between them have different preconditions to health and illnesses. For that reason, when describing illnesses and burden of diease in migrants it should be clear what particular migrant population is under study, for example, refugees from Syria, asylum seekers from Eritrea or unaccompanied minors from Afghanistan.

Sweden is recognized for and proud of having high quality register data, not the least health related such data (58). Nevertheless, these data have limitations when it comes to present burden of disease amongst migrants, since "migrant" is not a valid entity for national statistics on health. The closest one can get is a "person with a foreign background" (born in Sweden and having foreign-born parents) or foreign born compared with persons born in Sweden (59). Moreover, there are categories of migrants such as asylum seekers that does not appear in these register data since they do not have a residence permit, personal identity number (PIN) and have reduced access to healthcare services (2). This reduces, or better, makes it impossible to attain aggregated data on burden of disease among asylum seekers in Sweden, which of course is very unsatisfying, especially since the asylum process commonly is long-lasting, at times running for years (60). At a period of time during carrying out this research project newspapers reported that a number asylum seekers in Sweden had committed suicide. When trying to find out how many such tragedies that had happened I learned from the NBHW and The Swedish Causes of Death Register that suicides among asylum seekers are not included in the register, and therefore the total figures are unknown. Data from the Netherlands, however, confirm the elevated risk for suicide among asylum seekers, compared with the Dutch population (61).

Though migrants frequently are described as vulnerable and suffer from poor health there is on the contrary evidens showing that migrants in some cases appear to be healthy and even healthier than the host-population. This phenomina is called “The healthy migrant effect” and “Healthy migrant bias or hypothesis” (62, 63). However, as time pass by disparities, inequalities and health risks linked to the status of migrants and the migration process can emerge (64, 65).

Immigrants in Sweden, foreign born of non-European background report three to four times as often as Swedish-born people that they suffer from poor or very poor health (66). The predominant health concern among adult asylum seekers are various kinds of psycho - somatic disorders, which to a great extent are caused by stress during the asylum process combined with traumatic stress before the flight (60). Notwithstanding, asylum seekers frequently also suffer from physical health problems that cannot be disregarded (67).

To what extent CDs such as HIV, Hepatitis B and C and TB (Tuberculosis) are a threat to migrants depend to a large extent on the epidemiology of the country of origin and in transit countries. In Sweden, during the five-year period (2012-2016) an average of 455 new cases of HIV were reported each year. Of these, 75 % were foreign-born, most of whom were infected prior their arrival in Sweden. In 2015, a total of 450 new HIV-cases were reported, of which 329 (73 %) were foreign-born. Among the most common country of origin was at that time Eritrea, followed by Thailand. However, CDs may also under certain conditions be a threat to migrants in the host-country. As for people living with HIV (PLHIV) in Sweden, some are migrants and among them a majority had acquired HIV before arrival in Sweden but not all. In fact, during a five year period (2013-2017) a total of 384 individuals acquired HIV within Sweden and among them, 37% were born outside Sweden. When comparing that figure with the proportion foreign born living in Sweden as a whole in 2017, which was 18.5%, it appeared that foreign born in Sweden were over-represented among those having acquired HIV within Sweden during that period (68)(Personal communication 2018-09-18 with Torsten Berglund at the Public Health Agency of Sweden).

Among migrants being diagnosed for HIV in Sweden a significant number are late presenters, at least partly due to deficiencies in the healthcare system (69, 70), and that migrants themselves tend to avoid or “Fogging the issue of HIV” due to ideas about HIV brought along to Sweden from their country of origin (71).

Sexual and Reproductive Health and Rights (SRHR) is one of the determinants of health, and it is also dependent on other determinants and other health outcomes, such as physical and mental health. Thus there is a growing insight of the need to address issues related to SRHR within the scope of migrant’s health (72,

73). There is also a call for letting the work on HIV-prevention be carried out within this broader SRHR-umbrella (74, 75).

The Swedish healthcare system and policy on access

The Swedish healthcare system has an explicit public commitment to ensure health of all citizens and authorised residents. The Health and Medical Services Act (1982) is the foundation of healthcare policy that give clear directions on equal access to services on the basis off need and emphasises a vision of "equal health for all" (76). The Swedish healthcare system is mainly publicly financed by tax and organised into three levels; national, regional and local. At the national level, the Ministry of Health and Social Affairs is responsible for overall healthcare policy. It establishes principles and guidelines for care and sets the political agenda for health and medical care. Under the Ministry of Health are a number of expert agencies such as The Public Health Agency of Sweden and The National Board of Health and Welfare. The primary responsibility for ensuring that the inhabitants has access to good quality healthcare by means of both specialized hospital based care and primary care through a nation wide network of public and private health centers lies with the 21 county councils/regions. The more than 200 municipalities are responsible for long-term care for older people living at home or in nursing homes, and for those with disabilities or long-term mental health problems. The county councils and municipalities are given considerable freedom with regard to the organisation of their health services.

As for all Swedish healthcare, there are different sets of rules and regulations that apply to healthcare targeting migrants (76-78). Of these, the core regulation is Health and Medical Care for Asylum Seekers and Others Act (2008:344). It regulates the obligation for the county councils to offer asylum seekers and others health, medical and dental care. The Act codifies what previously applied under special agreements between the state and the Swedish Association of Local Authorities and Regions. Asylum-seeking children are to be offered the same health and medical care as children who are resident in the country. Adult asylum seekers are entitled to subsidised health and dental "*care that cannot be deferred*", maternity care, care when seeking abortion and advice on contraception. Ever since the concept "*care that cannot be deferred*" was introduced in policy documents, regulating the amount healthcare services asylum seekers should have access to, it has been discussed and questioned since no clear definition was presented and it created ambiguous interpretations and uncertainties among healthcare professionals. In February 2014, the National Board of Health and Welfare came to the conclusion that the terms "*care that cannot be deferred*" are "not compatible with ethical principles of the medical profession, not medically applicable in health and medical care and risk jeopardizing patient safety" (79). Anyhow, the term suggests restrictions on the entitlement, and what it may or

may not include remains ultimately a decision for health professionals in the specific situation (80). The law also makes county councils accountable for inviting the asylum seeker to a voluntary health assessment, which in fact becomes the sole active effort from health services to reach out to all asylum applicants and deal with their health concerns.

As of 1 July 2013 people who are residing in Sweden without permission are entitled to the same subsidised health and medical care as asylum seekers, i.e. emergency care. Children who are residing in the country without permission are entitled to full health and medical care, including dental care (81).

Health assessments

In the 1970s the major immigration to Sweden comprised of labor migrants from particularly southern Europe countries. However, it changed significantly in the 1980th when people from diverse countries in war and oppression increasingly arrived in in Sweden and other west European countries, in search for security and asylum (40). This coincidently happened in the era of the emerging HIV/AIDS-pandemic, and some asylum seekers had come from areas where HIV and AIDS had become highly prevalent (20). Until then, in Sweden, no systematic organized HA or screening for infectious diseases targeting immigrants existed. Since the mid-1980s asylum seekers have been offered an HA, which since 1990 also encompassed an HIV-test. Between 1985 and 1996, former Swedish Immigration Agency were responsible for the HA, but in fact it was outsourced to the county councils and carried out within the primary healthcare structure.

The idea that contagious diseases are imported by means of foreigners are deeply rooted worldwide (82). In USA for example, already in 1891 a law was launched giving the Public Health Service a statutory role in the assessment of immigrants (83). A similar procedure was later introduced in England (84). In contemporary Europe, health assessments for newly arrived asylum seekers have become a regular practice in most EU countries, but the content varies, if it is done voluntarily and how it is organized (85-87). According to Article 13 of the Reception Conditions Directive, EU Member States may require health screenings for applicants for international protection on public health grounds. There is, however, no obligation to undertake such screenings.

In the 1990s the newcomers were spread out in all Sweden and consequently, in 1997, the healthcare for asylum seekers, including the HA, became a responsibility for each of the 21 Swedish county councils. However, since each county council is sovereign as to how to organize and prioritize the healthcare for their inhabitants and the counties varied in regards to population, number asylum seekers, urban and rural living, economy etc. the healthcare and HA-service also came to

vary a lot, even though the state refunded the county councils for the cost of healthcare carried out on asylum seekers and other migrants.

In 2006, the Swedish Government launched the first National strategy on HIV-prevention (20). One of the three major targets in the strategy was, "HIV infection, in asylum-seekers and newly arrived immigrants that had come on family re-unification grounds, must be identified *within two months*, and within six months for other groups of people who have lived in high endemic areas." The same strategy pointed out the healthcare-sector as a most important arena to detect HIV in migrants, particularly in connection with the health assessment that newly arrived migrants were to be offered, according to an agreement between the Ministry of Health and the Swedish Association of Local Authorities and Regions (SALAR). However, the coverage of HAs had for a number of years, on a national average, been only around 50%, according to national statistics from SALAR, indicating a dysfunctional system. Therefore, on 1 July 2008, the agreement was replaced by a law on healthcare for asylum seekers (2). It did not oblige the asylum seeker to undergo the HA, instead it required the county councils to, "if not obviously unnecessary", reach out to each asylum seeker with an invitation to an HA, free of charge. This has been the only systematic attempt by which Swedish authorities try to tackle this issue.

The Swedish National Board of Health and Welfare (88) stated in year 2000 that the health assessment aims at identifying in asylum seekers' health related problems and to give information about the healthcare system and how to attain care at the right level when needed. It also aims to carry out effective measures of infectious disease prevention and control. The same report also reported that almost all county councils are lacking effective procedures to reach all asylum seekers with an invitation to the HA. There are also lack of routines to ensure a good quality and follow up of the services carried out.

Aims

General aim

To explore to what extent the Swedish healthcare system provides optimal conditions for asylum seekers to access the health assessment (HA) and how the HA could meet their own perceived health needs, as well as society's demand on detecting contagious diseases, from a public health perspective.

Specific objectives

- To identify variations in policies and implementation of HA for asylum seekers in Sweden. (Study I)
- To explore and improve understanding of how former asylum seekers from Eritrea perceived and experienced the HA during the asylum seeking process in Sweden. (Study II)
- To analyze the extent to which asylum seekers experience that the HA contributes to accomplish the fulfilment of their right to health. (Study III)

Conceptual framework

Several studies show migrants' limited access to healthcare (85). They point out various aspects obstructing the access (10, 22), as well as the reasons behind such barriers (89).

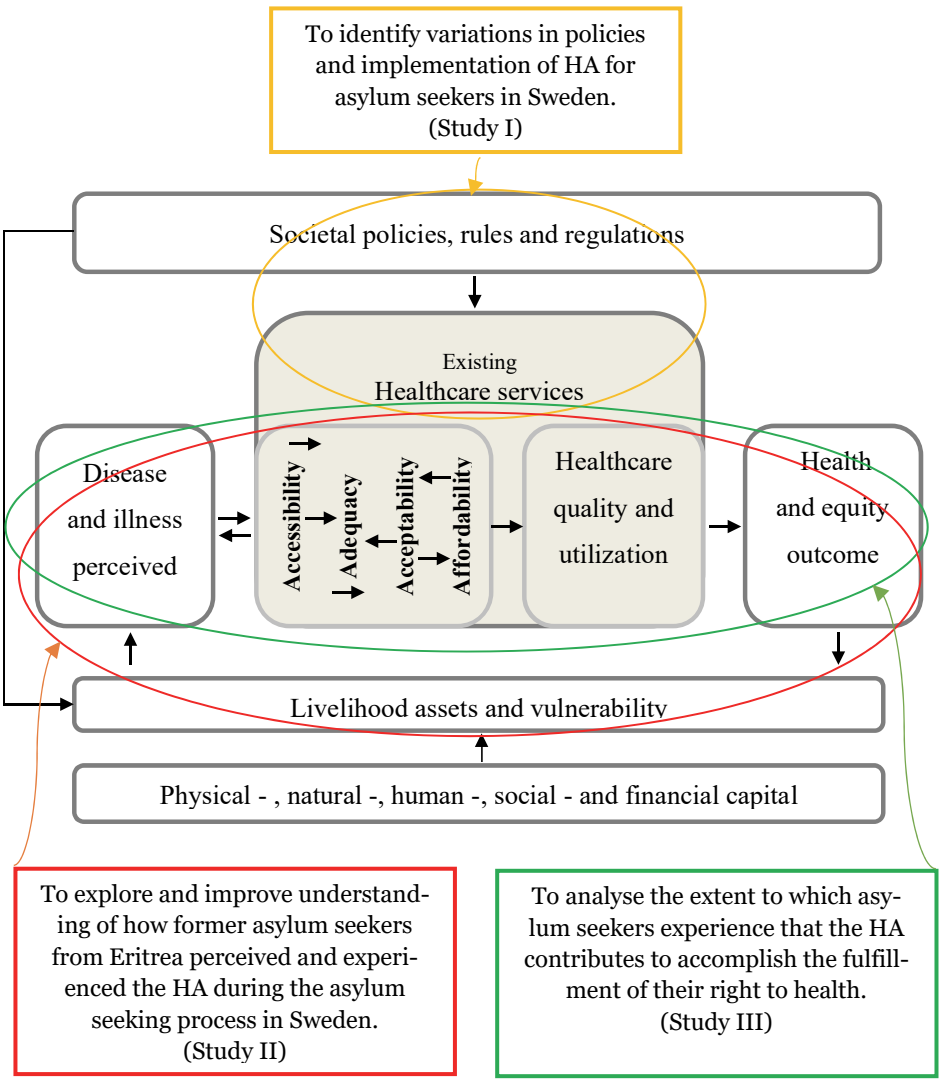
The extent to which migrants have access to healthcare in a host country reflects how the society has succeeded to implement a health system that allows everyone to enjoy the highest attainable level of health (90). It also mirrors the society's commitment to policies and strategies launched by international organizations such as UN, WHO, and EU, for example: "Health for all" (43), "Universal health coverage" (91), Equity in health" (92) and "Health in the SDG era" (Sustainable Development Goals) (93). These policies have been recognized by states worldwide, but to what extent these are implemented and complied with at national level varies.

In order to monitor its implementation, "the right to health" has been broken down into operational indicators. In a first attempt, the UN Committee on Economic, Social and Cultural Rights (CESCR) proposed four interrelated dimensions: *availability, accessibility, acceptability and quality*, commonly known by the acronym AAAQ (25). Two of these dimensions, accessibility and acceptability, comprised the core concepts in one of the three studies included in this thesis (22).

In a further development, Obrist et al (94) suggest a modification to the CESCR framework to adapt it to the analysis of populations in risk situations. Following the course of the health-seeking process, they propose five dimensions: *availability, accessibility, affordability, adequacy and acceptability*, applied in their "Health Access Livelihood Framework" - model. The authors argue that the degree of access reached along the five dimensions depends on the interplay between (a) the health care services and the broader policies, institutions, organizations, and processes that govern the services, and (b) the livelihood assets people can mobilize in particular vulnerability contexts. They also say that improved access and healthcare utilization have to be combined with high quality of care to reach positive outcomes, which can be measured in terms of health status, patient satisfaction, and equity. I found this model to be a suitable tool for analyzing and discuss the data of this research, in order to be well understood and used for further action and implementation. Further, this model was created within a theoretical thinking on barriers to access healthcare in contexts of livelihood insecurity, commonly experienced by migrants.

However, the framework by Obrist et al. did not in all aspects meet my thinking of how to organize and visualize the components of the model, and similarly the data in the best way. For that reason I have altered it and developed it further, as presented in figure 3.

Figure 3. The health ACCESS framework by Obrist et al., modified by R. Jonzon.



The three specific objectives of this research is linked to different parts of the conceptual framework, as visualized in figure 3.

The objective in study I was to identify variations in policies and implementation of HAs for asylum seekers in Sweden. To what extent access is achieved depends partly on the interplay between policies and the healthcare services. Rules and regulations aimed at steering the healthcare and its services may be generous or restricted as to for example physical resources, qualifications of healthcare professionals, quality assurance and entitlement to care, based on citizenship, migration status or/and health needs.

The objectives of study number II and III resemble each other in that both intend to capture the view of the asylum seekers in regards to the HA, based on their own experiences. Even though different research designs was applied in these two studies, one qualitative and the other quantitative, they almost overlap in the conceptual framework, since their objectives are similar. The central horizontal part of the framework, from left to right, illustrates the health seeking process, from illness to restored health. It can also be seen as the pathway from being entitled to a HA and trying to overcome barriers towards having the HA carried out. In this model the barriers are illustrated as layers of vertical filters, labelled *accessibility, adequacy, acceptability* and *affordability*, that needs to be passed through in order to obtain the HA. The arrows going in both directions illustrates that if the barriers are not mastered it may result in a return, backwards, instead of moving forward towards health, in a broad sence.

In this modified framework, *availability* is not explicitly presented as a barrier to access. Instead it is here seen as an entity that, a priori, exist and in this modified model labelled as "Existing Healthcare services". This entity of this framework includes, among other things, healthcare personnel, medicines and financial resources. These healthcare services may be simple or sophisticated, few or many, far away or nearby, but for most part they do exist. However, availability of these services does not per se guarantee that people have access to them.

The different components of this framework will be used to harbor and cluster data from any of the three studies and visualize how these, whether it has to do with healthcare regulations or livelihood assets, are interconnected by their impact on asylum seekers prospect to get through and overcome various barriers towards and while undergoing the health assessment. The barriers, accessibility, adequacy, acceptability and affordability, will in a similar way be linked to data, in order to reveal and clarify the negative consequences of the discrepancy between the migrants need and feelings and the various barriers.

In this framework, the barriers are illustrated as a filter that has to be permeated by the migrant, whether sick or just directing towards the health assessment. It may be possible to pass through one or two "filters", but maybe not the other, resulting in a return back to illness, uncertainty about ones health status and how

to navigate within the healthcare system. Even if having conquered the barriers, the health and equity outcome for the migrant will still depend on the general quality of the healthcare, as illustrated in the “flow chart” of the frame work that also will be exemplified by data.

Material and methods

Research design: Mixed method approach

Table 1. Summary of the three studies comprising the thesis.

Specific objectives	**Design**	**Participants**	**Time for data collection / Data set**	**Analysis**
I. To identify variations in policies and implementation of HA for asylum seekers in Sweden	Cross-sectional quantitative design	Healthcare personnel and administrators from all 21 Swedish counties	In year 2010. Two different questionnaires 315 + 20	Descriptive statistics were performed.
II. To explore and improve understanding of how former asylum seekers from Eritrea perceived and experienced the HA during the asylum seeking process in Sweden.	Qualitative design, guided by grounded theory	Former asylum seekers with Eritrean origin	In year 2013. Transcripts from 11 individual interviews	Data was analyzed according to grounded theory principles, using the paradigm model as a framework for categories and concepts
III. To analyze the extent to which asylum seekers experience that the HA contributes to accomplish the fulfillment of their right to health.	Cross-sectional quantitative design	Former asylum seekers being language students at the time for data collection	In year 2013. 1447 questionnaires distributed. Among them 386 fulfilled the inclusion criteria	Descriptive statistics were performed.

It is apparent to any researcher that the issue under investigation and the research question(s) that needs to be answered, will guide the choice of research design and method(s). Commonly, the choice is between qualitative and quanti-

tative design, and related methods and techniques to either design. When different designs and methods are used in the same research it is referred to as mixed method design (Table 1).

Quantitative research design

Quantitative design represents research methods drawn from the natural sciences, an approach known as positivism. It assumes that there is a single objective reality which can be ascertained by the senses, and tested subject to the laws of the scientific method (95).

In this research project a quantitative cross-sectional design was applied in study number I and III. Cross-sectional studies are carried out at a specific point in time, in contrast to for example retrospective or longitudinal studies, where the focus is on past and future respectively. This study design is often used to estimate the burden of disease or health needs of a population, in relation to public health planning and allocation of health related resources. A cross-sectional design is considered suitable in studies that have a descriptive purpose, commonly carried out in the form of a survey. However, they are limited by the fact that they are carried out at onetime point and give no indication of the sequence of events. Never the less, cross-sectional studies indicate associations that may exist and are therefore useful in generating hypotheses for future research (96).

Qualitative research design

Qualitative design has its roots in phenomenology and is aiming for a meaningful understanding of the individual, human awareness and the whole context of a social phenomenon (97).

In this research project a qualitative, interpretive and descriptive research approach was applied in study number II. It aimed at explore and improve our understanding of how asylum seekers, in this case from Eritrea, perceived and experienced the HA. No other studies on this explicit topic were to be found and thus very little pre-understanding of the subject was at hand. According to the two sociologists, Glaser and Strauss, that originally developed Grounded theory, the research approach chosen for study II, ideally the researcher should have little or no pre-understanding of the research problem (98). However, this orthodox view of "no pre-understanding" has later been questioned (99). Grounded theory offers a systematic set of procedures that seeks to create theoretical concepts explaining social phenomena and to inductively build a theory or a model from data grounded in reality. An emergent design is used i.e. the data collection and analysis take place in parallel and the researchers adapt the inquiry as the study pro-

gresses based on what has been learned in the study until then (100). The intension is to build a model or a theory, which could describe and possibly also explain the process of the main phenomenon, which in this study was "Influences on asylum seekers perception of the health assessment".

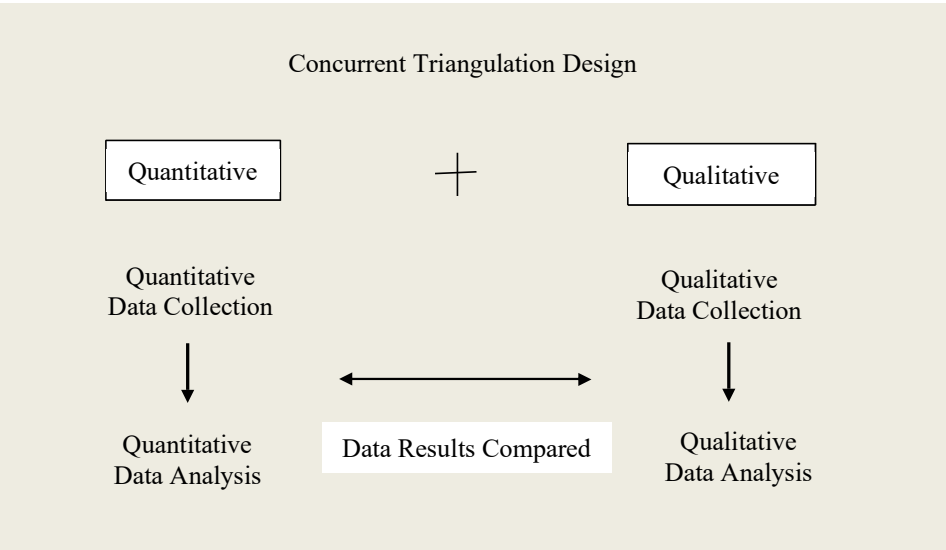
Mixed methods

Public health has developed out of the medical science field and were thus initially confined to issues such as diseases and its causes (101). However, today public health has broadened its scope and also evaluates how people themselves experience diseases and how economic, social and environmental factors influence health (18).

Debates about appropriate methodologies for studying public health problems have at times tended to be polarized. Traditionalists, advocating the use of epidemiology and other methods drawn from a reductionist research tradition (positivism) have tended to devalue the potential contribution of more interpretive research methods. Baum argue that the methods are simply tools that are used to further knowledge and have no inherent status as sound or unsound (101), while another scholar, Åsberg, has questioned the whole idea of distinguishing between qualitative and quantitative design (102). Public health problems result from complex causes and thus a range of methods are needed to tackle these problems. The question to be addressed should not be quantitative versus qualitative methodology, but how to combine different perspectives by using both quantitative and qualitative methodologies in a single study, while at the same time respecting the distinct branches of philosophical thought from which they are derived (97). Similar thoughts are put forward by Creswell (103) in saying that the problems addressed by social and health science researchers are complex, and the use of either quantitative or qualitative approaches by themselves is inadequate to address this complexity. Their combined use provides an expanded understanding of research problems (103) as well as to improve the validity of the findings (97).

With the development and increased legitimacy of using both qualitative and quantitative approaches in one single research project, mixed methods research has become a growing research approach (103). Mixed methods is also referred to as triangulation. Creswell has described six different mixed methods models (104), out of which the concurrent triangulation approach is to be the most common one, and also used in this research, Figure 4.

Figure 4. The concurrent triangulation mixed method model



Concurrent design. Adapted from Creswell et al. (2003).

In this research project a mixed method approach was applied (Table 1). In doing so a broader and deeper understanding of the phenomenon under study was expected and likely to be obtained. At the planning stage of this research no other published data were found on structural and procedural matters in relation to HAs of asylum seekers or other groups of migrants in Sweden. For that reason, an exploratory and descriptive approach was applied.

Study I

Study setting

The basis of the Swedish healthcare system is generally referred to as primary healthcare, consisting of local health centers. At this level, health promotion and preventive actions play an important role in addition to the care and treatment of illnesses that do not require specialized hospital based medical care. The health centers are commonly staffed by general practitioners (GPs), nurse practitioners and various other para-medicals. It is at these local health centers that HAs for asylum seekers take place.

Participants and sampling methods

The participants of this study were the appointed officers in each of the 21 county councils who were in charge of administrative matters in relation to healthcare

for asylum seekers. Further, clinicians, including both GPs and nurses, performing HAs of asylum seekers at each of the health centers, appointed to carry out HAs.

Questionnaire A was addressed to all appointed administrators (n = 21) in the 21 Swedish county councils, responsible for matters concerning healthcare for asylum seekers. Because one main focus of the study was to describe variations among the county councils in terms of structure and procedures in relation to HAs, all 21 county councils were included.

Questionnaire B was addressed to those primary healthcare centers within the 21 counties that were appointed to carry out HAs on asylum seekers, according to information given by each of the county councils. All units (n = 785) were included in this survey. The questionnaire was to be answered by any one healthcare personnel, individually or together, involved in the HA.

Data collection

Two different questionnaires (Appendix 1 and 2) were distributed, one targeting administrative staff and the other aimed at clinicians.

Both questionnaires were developed for the purpose of this research project. The questionnaires were pretested face to face individually with four nurses with significant experiences in both administration and clinical performance of HAs of migrants. At the fourth piloting, no need for further changes was identified.

In each of the 21 county counsel's one administrator were assigned to handle issues related to migrants' healthcare within the county. One questionnaire, together with instructions, was sent to that one administrator, commonly placed at the county counsel head office. Another questionnaire was sent to the head of each of the 785 primary healthcare centers in Sweden that were assigned by the county counsels to carry out HAs on migrants. Only one questionnaire per healthcare center was to be filled in and sent back.

After the postal questionnaires had been sent out, two reminders were distributed at different times, before the closing date four months later.

The questionnaires had considerable content overlap, thus allowing for comparison of the results. The questions covered demographic characteristics of the participants, healthcare organization and procedures, competencies and responsibilities, performance management, information and communication, and performance monitoring. Both questionnaires mainly contained questions with fixed

response alternatives, although some questions also had open-ended response alternatives.

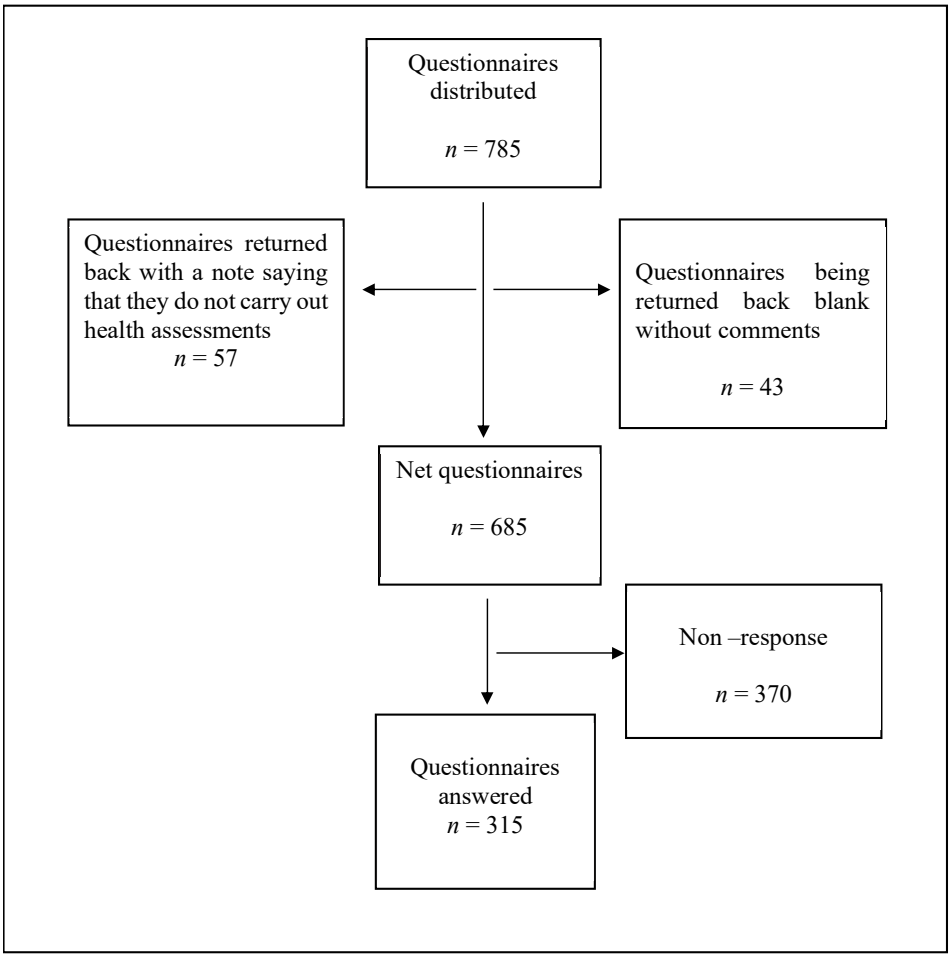
Data analysis

Analysis of non-responders for questionnaire A and B.

Questionnaire A. One of the county council's central administration was missing. In addition to two written reminders, a telephone call was made to confirm that the questionnaire was received.

Questionnaire B. Among the 470 non-responders, 57 returned the questionnaire blank with a note saying that they did not work within the concerned field, which led us to suspect that there was an over coverage. Another 43 returned the questionnaire blank, without a note, and the remaining 370 did not reply at all. (Figure 5)

Figure 5. Flow diagram of respondents of the survey and eligibility for the study.



In order to be able to explain the relatively high number of non-responding healthcare centers, a county-stratified random sample was drawn. The sample size calculations assumed a 35% chance that a non-responding healthcare center was not providing HAs on asylum seekers. Furthermore, a precision of 5% for the confidence interval for the estimate of the total number of non-providing healthcare centers was assumed. The calculations yielded a sample size of 213 of the 470 health centers that did not participate. The 213 were contacted by telephone and almost all (199) said the reason for not responding was that they, at the time of the survey, did not carry out HAs on migrants. Based on this figure, we estimated the proportion of the over coverage to be 94% [95% CI (91% to 96%)], which we consider to be a significantly high over coverage, and thus these are not true non-responders. The explanation for this is that the inclusion crite-

rion was health centers appointed to carry out HAs on asylum seekers, but in reality only part of them actually carried out HAs. Thus, only those health centers that in fact carried out HAs should have been selected to participate, instead of all that were appointed to carry out these services.

Analysis strategy for questionnaire A and B.

Descriptive statistics were performed to summarize and analyze the data (97). As for the data from questionnaire B frequency distributions were calculated using the statistical package Stata 13.0. The answers to the open-ended questions were analyzed by means of qualitative content analysis (105).

Study II

Study setting

The interviews with former asylum seekers from Eritrea took place in a language school for immigrants, in one of Stockholm's suburbs. The school was situated in the neighborhood of the homes of most participants. The interviews were held in the evenings when no ordinary school activities took place. This was considered to be a neutral place where the participants could feel comfortable and safe.

Participants and sampling methods

The selected participants comprised of former asylum seekers from Eritrea. The reason for choosing Eritreans was that they, at the time for initiating this research, comprised one of the biggest groups of third country nationals applying for asylum in Sweden. Further, Eritrean nationals were at that time also among those commonly diagnosed with HIV in Sweden. At the time for the data collection, all participants held a residence permit in Sweden and resided in various suburbs to Stockholm.

The participants were initially purposively selected with the assistance of a trusted key person, a civil servant in the municipality, responsible for the local introduction program for refugees. Eight persons were initially recruited, four women and four men. Three more persons, one woman and two men, were later added to ensure data saturation.

Data collection

The data were collected using individual face to face interviews, where an interview guide (Appendix 3) with introducing questions and probing areas was used. Individual interviews are recognized to be suitable when addressing sensitive questions on health issues (106-108) such as strategies and behavior to achieve a

good health, experiences from health care services, experiences from health assessments and tests for HIV etc.

The data collection took place in a language school, considered to be a neutral place, where the participants would feel comfortable and safe.

I conducted the interviews, with assistance of another researcher as an observer. The interviews were held in Swedish with support from a specially trained interpreter. The interviews were documented by a digital recorder.

The interviews followed a thematic guide and the questions were "broad", such as

When you became sick in Eritrea, what health care services were there to assist?

Tell me of your first encounter with the Swedish health care?

Each of the interviews ended with a member check, where the researcher made a summary of the main topics. By doing so the informants could adjust/alter their comments immediately, while the topics discussed were still fresh in mind. Their comments were recorded at the same time. After each interview the researcher and the observer discussed the interview process and topics of special interests that needed to be further looked into. Besides, memo writing was carried out by the researcher.

Data analysis

The interviews were recorded, transcribed verbatim in Swedish and analyzed according to grounded theory principles, using the Paradigm model (106, 107).

The Paradigm model requires identification of context, causal conditions, intervening conditions, action/interaction and strategies and how categories and underlying concepts relate to each other and to the core category. Finally, this process results in consequences that also are part of the model.

The analyses were done by the first author in continues collaboration with the co-authors. The first phase of the analysis took place immediately after the interview, when the interviewer and the co-researcher, acting as observer, discussed and analyzed the data. When crucial issues were identified, these were then used in the subsequent interviews as part of the emergent design in order to develop and refine the quality of the data (100).

Study III

Study setting

Data was collected in language schools for former asylum seekers and other migrants. These were located in four different counties of Sweden (Norrbotten, Skåne, Östergötland and Stockholm), situated from the very south to the very north. These counties also represented both highly densely populated cities and less populated urban towns.

Participants and sampling methods

Eligible participants for this study were former asylum seekers registered as language students. We assumed that all former asylum seekers at the language school had received an invitation to an HA. A second inclusion criterion was that the participants had sought asylum in 2010 or later. The reason for excluding earlier applicants was that the law on healthcare for asylum seekers was indorsed in 2008 and we assumed that it was implemented in all counties in 2010.

In total, 1447 questionnaires were distributed while some less, 1412 completed the questionnaire. Of them, 890 were in Arabic, Somali, Farsi and Tigrinya, and 522 were in other languages. Five hundred seventy-seven of the respondents had come as asylum seekers, and 263 came as relatives to asylum seekers. The rest, 572 respondents, came to Sweden for other reasons, such as work, studies or establishing a relationship with a Swedish citizen. Among the 577 former asylum seekers, 191 came to Sweden before 2010, and 386 arrived in 2010 or later. Thus, these 386 individuals, who were within an age range of 18 – 65 years, fulfilled the inclusion criteria for this study, namely, being a language student, having sought asylum in Sweden in 2010 or later, and mastering at least one of the languages used in the questionnaire.

Data collection

This study was based on a structured questionnaire (Appendix 4) that was translated into the languages spoken by the largest groups of asylum seekers in Sweden in 2010 and later, namely, Arabic, Somali, Tigrinya and Farsi. It was also translated into the most prevalent European languages (English, French and Spanish) based on the consideration of the expansion of these languages worldwide and that some asylum seekers might have come from countries where these languages are spoken.

The questionnaire consisted of 51 items. Some had been used in the Swedish national public health survey, Health on equal terms (HLV), others were elaborated by the researchers based on interviews with health care providers, discussions

with target groups and relevant literature about health assessments (109, 110) and the right to health (111). Most of the items were closed ended questions, related to six topics: 1) socio-demographic background, 2) general knowledge and perceptions about health and health care, 3) information received prior to the health assessment, 4) knowledge and perceptions about the health assessment's purpose and contents, 5) communication with health care providers and others involved in the health assessment and 6) the health assessment in relation to individual health needs. Questions about the reasons for migration and the year of entry to Sweden were also included in the questionnaire. These allowed the respondents with an asylum background to be diverted to the specific questions on the health assessment and their answers to be sorted out during the data analysis.

The questionnaire was initially produced in Swedish and was translated into the other languages. The translated versions were piloted with migrant students at language schools in

Stockholm and were adjusted, according to their suggestions, before being used. Language supporters were available for those students who could not read and write the respective language, but wanted to participate. These supporters were persons who mastered the language of the respondent and had either been working as interpreters or had experience in research.

Data analysis

The data was analyzed to reveal the extent to which the respondents considered the information, procedures and services related to the health assessment to be accessible and acceptable, because these are essential dimensions of the right to health, according to the CESC. *Accessibility* was analyzed by three variables: universal access, language and communication, and health-related information. *Acceptability* was analyzed by the variable: cultural appropriateness, it means respect for cultural differences. Frequency distributions were calculated using the statistical package Stata 13.0.

Ethical considerations

Migration attracts considerable political attention and ranks high on national and international policy agendas. Commonly, there are polarized ideas on whether migrants add value to their host societies or they just drain resources from the same. When, under such conditions, research focus is on migrants' health and access to healthcare services, the disclosed and disseminated data may be used to argue both sides.

There are many ethical complications in conducting research with uprooted people (28), who have often been exposed to persecution and marginalization in conflict situations, refugee camps, immigration detention settings, and following resettlement (112). Therefore, researchers need always to discuss the ethical implications of their research methods, strategies, questions and findings to properly justify their choices (113, 114).

Research has always a political dimension, not the least research on migration. Researchers touching such sensitive issues as migration and health should openly acknowledge this. This demands the researcher to act in a morally responsible way, abstain from ideological statements and present results in a balanced and careful manner, in order to avoid to do harm to the people under study. Further, according to Düvell, they should be as explicit and as aware as possible of their own views and preferences and openly discuss it (113).

Another researcher, Birman, argues in a similar way that research on refugees is not morally neutral (115). Hence, research on migrants place great responsibility on the researcher that must use ethical codes to assess the ethical questions involved in their work. Birman says that ethical research cannot be conducted across cultures without involvement of members of the community being studied. She refers to such community members as "cultural insiders". In this research project such involvement was in place. In study number II, a trusted civil servant with the same country of origin as the informants, was involved. He recruited the informants, introduced the research project to them in their native language as well as served as an interpreter, when necessary, during the interviews. In study number III the "involvement of members of the community being studied" was limited to activities in relation to the data collection. In the language school where the data collection took place some cultural and language mediators, representing different countries and languages, assisted the participants while answering the questions. Moreover, this research was to great extent about listening to

For each of the three studies a written approval for the research project has been received from the Regional Ethical Review Board in Stockholm (Study I and II: Reference number 2012/1245–31/5. Protocol 2012/5:7) and from the Regional Ethical Review Board in Umeå (Study III: Registration number 2014-11-32M). Detailed information on ethical considerations concerning the individual study are to be found in each paper.

The principles of the Helsinki Declaration, often regarded as the cornerstone document on human research ethics, has been acknowledged throughout and was applicable in this research project (116). However, despite its prominence, it has been argued that it has less value in public health research in contrast to research on individual's health (117).

Focusing on *former* asylum seekers was a deliberate decision based on both ethical and methodological reasons. We considered that questioning current asylum seekers on their experience of the health assessment could increase anxiety produced by the pending decision on asylum (118), which in turn could affect the consistency of their answers. In addition, it was likely that some had not yet undergone the health assessment, and therefore, would not be able to answer the questionnaire. We also decided against including asylum seekers whose applications had been rejected because of difficulties in finding them, and because the anxiety provoked could be higher due to their particular situation (113, 119).

Results

A summary of the main findings is presented below. A complete presentation of each of the studies is given in the individual papers I – III.

In this chapter the modified access framework model (Figure 3) is used to present and analyze the overall results.

Study I

To identify variations in policies and implementation of HA for asylum seekers in Sweden

There are various rules and policies that are to guide and steer the healthcare within certain frames. Healthcare professionals are to comply with such rules and thus they have an impact on the barriers to access healthcare for asylum seekers and other migrants. The results from this study clarifies to some extent these two aspects, policies on one hand and the healthcare services on the other, as well as it clarifies the first specific objective in this research project, namely; to identify variations in policies and implementation of HAs of asylum seekers in Sweden.

Healthcare personnel

Healthcare and various healthcare services cannot be carried out unless there are skilled healthcare professionals, administrative and financial support and medical equipment etc. As visualized in the conceptual framework (Figure 3), healthcare and its personnel operates within given legal and policy boundaries. This in turn may lower or elevate barriers to access healthcare for asylum seekers and other groups of migrants.

The result from this study reveal a characteristic diversity among both the administrators and the healthcare personnel. In both groups the proportion females was bigger than males, 16 (80%) administrators and 247 (78%) clinicians. Among the clinicians, a majority of the respondents were nurses, 217 (69%). Both groups comprised foreign born individuals, 4 (20%) administrators and 25 (8%) clinicians, which to some degree mirror the proportion foreign born in the country as a whole. There were few both administrators and clinicians that had had any special training in relation to migrant's health. Among the clinicians 55 (18%) had experience from similar work abroad. Ten (50%) of the administrators and 161 (51%) of the clinicians had less than five years in their work position.

Healthcare services, its organization and structure

As skilled healthcare professionals are a prerequisite for well-functioning healthcare services, so are the organization and structure in which they are working. Depending on these factors it will lower or elevate barriers to access healthcare for migrants, when trying to obtain these services.

The number of healthcare centers in each county that carried out HAs on asylum seekers varied significantly, from one to more than ten, independently the size of the county. Among the clinical respondents 282 (90%) reported that the HAs were carried out in "ordinary healthcare centers", in contrast to some specially formed units for this purpose. Among the administrators, 19 (95%) indicated that their county had a centralized support function for those working in the healthcare centers, carrying out HAs on asylum seekers. On the contrary, only 91 (31%) clinicians recognized the existence of such a centralized support function in the county, thus a major discrepancy.

Healthcare services, its competencies and responsibilities

The administrators commonly reported being located at the central county council office and some indicated that they themselves constituted the central support function, aimed at the clinicians. Their main duties related to administration and finances, but also legal and policy matters. They also functioned as a link between the migration authority and the clinicians.

The HA comprised the core duty for all GPs and nurses, but in what way and to what extent the workload was shared between these two professionals was diverse and not clear cut. Among all the respondents in this study, GPs and nurses, 192 (61%) also had administrative duties, besides the clinical work. These duties were to some extent identical to those being carried out by the administrators.

Only 63 (20%) of the clinicians had access to professional supervision at work, when at the same time 44 (14%) felt that they did not have sufficient qualifications needed for doing their work in a satisfactory way. However, about one third of the clinicians had access to specialist consultants, such as pediatrician, gynecologist/obstetrician, psychiatrist and psychiatric nurse, but for the most merely on telephone. Only 40 (12%) of the respondents considered the psychiatric consultation to be sufficient and similarly, only 56 (18%) reported that the possibility to consult a psychiatric nurse were sufficient.

Healthcare services, and the health assessment (HA)

As healthcare services in general are confined to laws and regulations, so is also the HA that the healthcare in Sweden is obliged to offer asylum seekers. To what degree the healthcare comply with these rules may also have implications on the

barriers that tend to lock some asylum seekers out from their right to access the HA.

The starting point for the HA process is the invitation to the same. The data reveal that 192 (61%) of the healthcare personnel reported using a written invitation to the asylum seekers, in Swedish. However, 256 (81%) reported that an interpreter was involved during the HA.

The content of the HA varied among the counties. Despite the rule that information on the Swedish healthcare system should be part of the HA only 201 (64%) indicated that this essential information was communicated. Issues related to communicable diseases seemed to be prioritized. Tests for TB and HIV seemed to be considered a rule since 234 (74%) acknowledged carrying out TB-tests and 248 (79%) HIV-tests. However, although information booklets on HIV and other STIs has been produced and translated into many languages, only 91 (29%) reported having these available for the migrants, at their local health center.

Healthcare services, managing and monitoring quality

In order to harmonize services and create an equitable healthcare system, the need for steering documents and guidelines is commonly recognized. In this study, only 14 (70%) of the administrators and 158 (50%) of the healthcare personnel reported that such steering documents, specifically written to guide healthcare services targeting asylum seekers and other migrants, were in place, at county level.

Among the healthcare professionals, 217 (69%) indicated having written guidelines on the content and performance of the HA. However, methods and measures need to be evaluated continuously, developed, and improved, which also applies to the HA services targeting asylum seekers. Among the administrators, only 9 (45%) reported that systematic efforts to improve methods were implemented in their county. Almost exclusively, the examples given were about improving guidelines and checklists related to the actual HA.

The respondents were asked if they had established procedures to carry out annual follow ups on the HA process. Among the administrators 10 (50%) indicated that they had what was needed to do such annual follow ups and as for the healthcare personnel only 135 (43%) stated having such procedures in place.

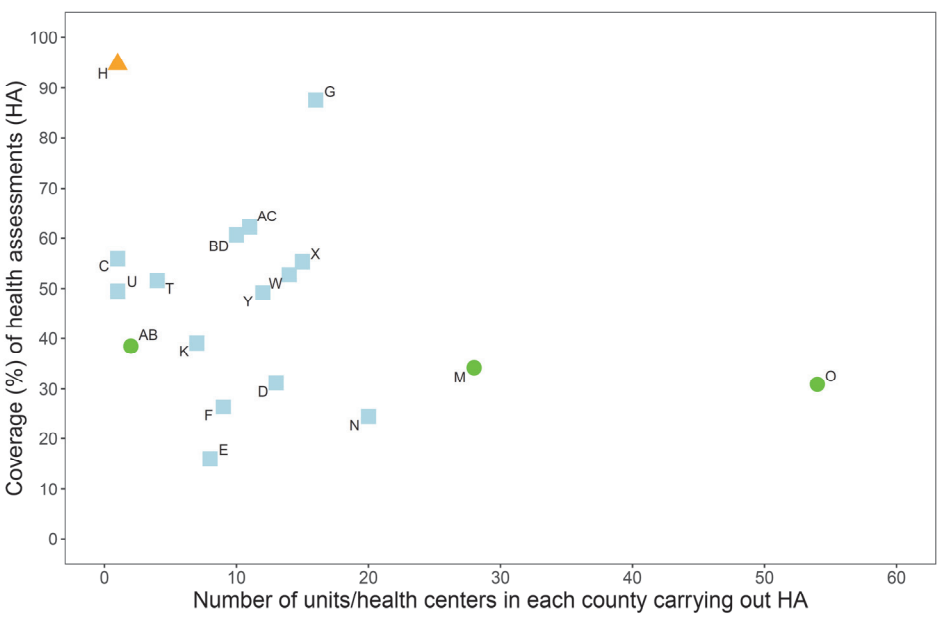
The respondents were asked to indicate the proportion of asylum seekers having arrived during the previous year, in relation to all asylum seekers in the county and in the area assigned to their local healthcare center, respectively, who had an HA carried out during the previous year in the county as a whole (administrators

at county level) and in the healthcare center where they worked (healthcare personnel). There is a significantly high number of missing values on this issue. Among the administrators 12 (60%) and among the healthcare personnel 228 (72%), indicating that they probably did not know.

Finally, the healthcare personnel were asked whether a specific follow up was done in order to find out the reasons to why asylum seekers did not turn up for the HA despite an invitation or declared intent not to attend. Among those who replied, 31 (10%) answered that they did try to determine the reason behind the dropouts, 176 (56%) did not, and 48 (15%) did not know if such inquiries were made.

Data from this research was published in BMC Health Services Research (2018) 18:813 (70). However, there are additional data that were not included in the paper. A most interesting finding was that one of the 21 Swedish counties, a mid-sized county in the south, presented a distinct different organization and working process in relation to the HAs offered to asylum seekers. The uniqueness in their approach was the use of a specialized mobile health team that reached out to all parts of the county, where the asylum seekers had their temporary living. When analyzing national statistics on HAs for asylum seekers we also found that that particular county, having a mobile health team, also presented significant higher number of HAs carried out, in comparison to all the other counties. Figure 6.

Figure 6. Coverage (%) of HAs carried out in relation to the number of health centers in each county carrying out HAs.



The orange triangle, marked with letter H, represents the county having a mobile health team. The three green circles AB, M and O, represents the three most populated areas in Sweden, also hosting the three biggest cities. Notably, all three regions present an equally relative low coverage, independently of the different number of health centers carrying out the HAs on asylum seekers. The cluster with blue squared symbol represents the remaining counties, showing a relative homogeneous picture.

Study II

To explore and improve understanding of how former asylum seekers from Eritrea perceived and experienced the HA during the asylum seeking process in Sweden.

According to the modified access framework (Figure 3), the degree to which various barriers hinders access to healthcare, including the HA offered to asylum seekers in Sweden, depends not only on the interplay between policies and the healthcare services. It is also to a great extent depending on migrants' livelihood assets and vulnerability, which in turn are influenced by rules and regulations. The migrants' livelihood assets and vulnerability are basically also dependent on their physical -, natural -, human -, social -, and financial capital, which is shaped from the pre-migration time, during the actual migration as well as from the time in the host society. This in turn will influence the migrant's health status and need for healthcare services. The result from this study show that the part of the healthcare system that is responsible for the HA have various barriers that reduces the access to HAs and other healthcare services.

Livelihood assets and vulnerability

The informants had left oppression and hardships in their country of origin, but to some, the journey became an even worse experience, which they sensed too difficult to talk about. A state of limbo summarizes the feelings and experiences communicated by the informants, such as separation, vulnerability, uncertainty, unpredictability, lack of trust, social exclusion, and marginalization. Furthermore, it captures the inability to overcome the language and cultural barriers.

Insufficient communication

Almost all of the informants in this study had received a written invitation to the HA from the local healthcare authority. However, because the invitation was written in Swedish many did not understand its contents or why they received the invitation and what intention it had.

"I did not understand the purpose of the health assessment. I just received the invitation and my interpretation was that I had to go there." (Man, 35 years)

One purpose of the HA offered to newly arrived asylum seekers is to convey information about the Swedish healthcare system. However, no informant had received such information.

The informants frequently compared health related experiences from Eritrea with experiences of the Swedish healthcare. They said that thoughts and actions that would have been rational in their old context were not applicable in their new setting, which added to the feeling of being in a state of limbo. Several informants said that they thought that an HIV test had been carried out at the HA, but they did not know for sure. In contrast, it was more common to know that a test for TB had been done, because they were told to come back to the clinic after three days to show the result of the skin reaction.

"I did not receive much information. She explained about the TB test, but I got no information in relation to the blood test. I still do not know." (Woman, 28 years)

Some of the informants said that testing for HIV was a comprehensive measure in Eritrea. This included pre-test information on the disease that described that it is a chronic but treatable disease and described the routes of transmission. They expressed how they felt well informed ahead of their HIV test in Eritrea, but on the contrary they expressed disappointment over the lack of information in connection to their HIV test at the health assessment in Sweden.

"They did not ask. They just took the blood, three times, without saying anything." (Man, 27 years)

"In Eritrea, all of the people are gathered together for one hour before the blood test in order to get information about the disease. This is information on how the disease is spread, what happens to anyone testing positive, and how to protect yourself. They say it is an ordinary disease… almost." (Man, 36 years)

Conflicting rules and regulations, feelings of ambiguity and mistrust

The HA took place at a time when the asylum seekers were predominantly occupied with thoughts and worries about the outcome of their asylum application.

They expressed how their main focus was on the legal process related to the asylum application, and their thoughts about their own health and health-related needs became secondary.

In contrast to the fact that the HA is optional, several of the informants expressed how they thought it was mandatory.

> *"I received a letter in Swedish with the time for the assessment, and that made me interpret it as compulsory." (Man, 35 years)*

The informants repeatedly reported that the HA was the first encounter between them and the Swedish healthcare system. They expressed uncertainty as to whether the HA would contribute to their health, and their expectations for the HA seemed to be low. The informants perceived that the focus of the HA was restricted to blood tests, and they expressed disappointment for not being given the opportunity to bring up and discuss their own perceived health needs and concerns.

The asylum seekers expressed a sense of ambiguity and mistrust both in their meetings with the migration authority and with the Swedish healthcare system. Uncertainty and a sense of insecurity were expressed regarding what role the migration authority had in relation to the healthcare system.

> *"It is the migration authority…on their assignment the health assessment was carried out… and the migration authority wants to know [the results]. It was so stressful." (Woman, 38 years)*

Several informants shared, they perceived themselves to be subjected to circumstances and situations that they could not influence. The informants expressed sentiments of hopelessness and a lack of real power to act or change the situation they were in.

> *"What could I do but to comply, I had no choice." (Man, 27 years)*

The informants further expressed that the asylum-seeking process seemed to be a procedure that could not be altered or influenced by the individual. No informant articulated any notion on rights, only on how to comply with the system, with the ultimate purpose in mind, to obtain a residence permit. Because the HA was seen as part of the asylum-seeking process and linked to the legal aspects of the process, the informants described how it was logical to maintain an attitude of obedience and compliance in this area.

Study III

To analyze the extent to which asylum seekers experience that the HA contributes to accomplish the fulfillment of their right to health.

The data from this study was originally analyzed by the AAAQ - concept, representing essential dimensions of the right to health, according to the UN's Committee on Economic, Social and Cultural Rights (CESCR). This study, however, focus only on the extent to which the respondents considered the information, procedures and services related to the HA to be *accessible* and *acceptable*.

Disease and illness perceived

About half of the respondents, 196 (51%), reported suffering ill-health at the time of arrival in Sweden. Among the different health problems presented, psychological disturbances were more common than others. As many as 225 (58%) reported feelings of loneliness and isolation and 129 (33%) reported having no one with whom to share worries or problems.

Accessibility

Accessibility means the possibility for everyone to reach health facilities, goods and services without discrimination.

Universal access.

In this study, 48 (12%) of the former asylum seekers that participated in this study did not undergo the HA. They presented different reasons for that, but among them, as many as 31 (65%) indicated not having received an invitation to the HA. Among them, there were complaints about having lost the opportunity to know their health status and to obtain treatment for or advice about their health problems. Amid those who received an invitation to the HA but refrained from attending, 5 (10%) indicated that they simply did not want to attend and 3 (6%) that they did not understand what it was about. Other, but less common reasons for not attending were previous bad experiences with healthcare in Sweden, doubts about getting medicine or treatment or just feeling healthy and no need for the HA.

Language and communication

Among the 338 (88%) respondents who attended the HA, only 302 (78%) reported having received the invitation letter. Of them, 293 (97%) also indicated that the letter was issued in Swedish, and thus few stated that they understood the content. Similarly, of those who attended the HA, 108 (32%) said they had not been informed that the HA was a right or that they could abstain from it. Moreo-

ver, as many as 98 (29%) believed that the assessment could influence the decision on asylum, and 87 (26%) indicated that they had not been informed on their limited access to health services.

Regarding the direct communication with healthcare personnel, 269 (80%) indicated that interpreters were provided. However, only 170 (63%) said that they had understood what the doctor or nurse had said. Similarly, of those attending the HA, 241 (71%) reported that samples were taken, but only 171 (51%) knew what kind of samples, and even fewer, 149 (44%) knew the results. Additionally, among those attending the assessment, 100 (30%) said they had not had the opportunity to express their own felt health concerns. They also complained about the short time assigned for the HA.

Access to health-related information

Among those who attended the HA, 259 (77%) considered it to be primarily a communicable disease control, on the cost of focusing on other health needs. Nevertheless, almost one third indicated that they had not received preventive information about HIV, STI or TB, or information about contraception and family planning. Likewise, 76 (29%) of the respondents indicated that they did not know whom to contact if they had a need for psychological support.

Acceptability

Acceptability implies respect for medical ethics and cultural appropriateness.

Unattended health needs

Out of the 196 (51%) respondents that reported they had health problems during the first months after arrival, 174 (89%) underwent the HA, but 96 (55%) indicated not having received any treatment or advice. Healthcare was often denied when it had to do with psychological disturbances, as indicated by 21 (66%) of those 32 (16%) individuals who reported such needs. In contrast, they perceived that more attention was paid to individuals who expressed other health needs.

Cultural appropriateness

Although a majority of the respondents reported that they had been treated respectfully during the health assessment, 37 (11%) had a different opinion. Some expressed distrust of the person who carried out the HA or indicated that they felt offended. They referred to language difficulties, ethnicity, culture and gender aspects as the reasons for the misunderstandings and dissatisfaction in their encounter.

Discussion

In this section I discuss the overall results of this research project and what implications it may have on amending present structure and procedures related to the HA offered to newly arrived asylum seekers in Sweden. Similar to the previous chapter, on results, the modified access framework model (Figure 3) will guide the discussion part.

The overall aim for this research project was formulated in a context of many years of a low coverage of the HA among the increasing number of asylum seekers arriving in Sweden. At the same time a growing body of evidence appeared showing that migrants, not the least asylum seekers, are vulnerable in relation to health (120-122) and that they present a poorer self-perceived health than the general population in the host countries (123). Available data reveal that asylum seekers commonly suffer from significant psychological distress (124, 125), but also other kinds of ailments that need attention (72, 126-128). The HA has in both policy documents (20) and in the discourse of public discussion frequently and foremost been associated with a notion of a need for more immediate detection of infectious diseases, not the least HIV and TB, in order not to transfer these plagues to the host population (64, 129). However, the HA offered to asylum seekers in Sweden has, at least formally, a broader purpose (2).

The main results of this thesis indicate the lack of a coherent national system and approach to facilitate healthcare services, in this case with focus on HAs, for asylum seekers. Though national policies do exists, there are no common pattern as to how these are implemented and applied at regional and local level, to guide how to organize services and procedures in relation to the HA. Moreover, there seemed to be no national supervision or professional training options available to the health professionals working within this field. Even though the HAs most commonly are carried out in ordinary primary healthcare centers, the data reveal a picture of a parallel system where citizens are provided healthcare on different premises than asylum seekers and other categories of migrants.

Though the main purposes of the HA is to identify health problems that require immediate attention, detect infectious diseases and to give information on the Swedish healthcare system, our data indicate that this is not fully accomplished, nor in a satisfactory way. The focus is to a large extent on control of communicable diseases and less on care for illnesses perceived by the asylum seekers. Poor communication and information to the asylum seekers before, under and after the HA contribute to building barriers that reduces the prospect of accessing healthcare for the asylum seekers. Despite that the asylum seekers considered the

quality of the HA to be unsatisfactory, and that it did not contributed to the fulfillment of their right to health, they embraced the offer as such, of having an HA.

Migration and migrants' vulnerability

As already stated, migration is not a new phenomenon (26). However, in the past, what happened in various parts of the world, for example larger migratory movements, was not known to the general majority of people. The good and bad that happened to the migrants at that time were probably for the most part known only to those being part of the movement. Today it is different, since we are equipped with all possible tools and skills to know what is going on simultaneously in various parts of the world, at any time. It gives us opportunities, but also accountability to comply with and act in accordance with international agreements and national policies, aiming to reduce migrants' vulnerability and secure their right to health and wellbeing (130).

In recent time, the magnitude of migration to Europe reached heights beyond what most people or governments had experienced before or were prepared for. There were obviously limited readiness and success in managing the situation, that commonly came to be called, the European migration crises (131). This were at times referred to and described as a threat and destabilizing factor to Europe, its nations and people (129, 132). However, what really ought to have been a main concern was the many vulnerable people, jeopardizing their lives and health on risky journeys, towards what they hoped for, a safe refuge (133).

Migrants' livelihood assets and vulnerability (Figure 3) may be different, since migrants are a most diverse entity. It might always be a challenge and to some degree stressful, to move from known places and environments to something unknown, whatever the reasons behind the migration might be. However, to many, those who never had chosen to leave, but were forced to do so because of life threatening circumstances, to them the imposed migration put them in a livelihood assets with great vulnerability (134). This was the case also to many of the participants of this research. They said, they felt compelled to leave their native country, since there was no future (21). Some had experienced being forced into the army with no return, with no hope to be free ever, unless escaping, knowing what risks it might lead to. Their vulnerability was present at all stages of the migration process. The informants told that for some it took weeks, for others years, from having crossed the Eritrean border to finally reaching a country where they could apply for asylum. The experience of being an undocumented migrant in foreign countries, left to smugglers and risky travels by land and sea was said to be a threat that made them feel even more vulnerable (21).

Migrants having entered Sweden and applied for state protection according to international treaties become per definition asylum seekers. Though having reached a country that recognizes international laws and human rights they remained in a vulnerable position as to various social determinants of health (18, 135) which was expressed by informants in one of our studies, saying that the time after arrival in Sweden was very troublesome (21).

Swedish policy's on where asylum seekers should live while awaiting pending decision on their asylum application has altered over time (136). The choices have been either in a collective living in a place provided by the migration authority (ABO) or together with friends, family and relatives in private homes (EBO). It can be assumed that both options might enhance social interaction and prevent isolation. In our data, every other respondents had lived together with other asylum applicants during the asylum process but almost two in three reported feelings of loneliness and isolation and one in three reported having no one with whom to share their worries or problems. Separation from family, inability to communicate both culturally and linguistically, being in a limbo awaiting decision on their asylum application caused in many severe mental stress and suffering. In fact, data from one of our studies (22) revealed that among those more than 50% respondents, slightly more men, that reported suffering health problems at the time of arrival, mental health issues was most common. This is in line with evidence from many other studies (57, 124).

Migrants and public health

The public health status, whether global or national, is dependent on numerous factors. The social determinants of health have increasingly been recognized as a major factor to the status of health, on both individual and societal level (12, 18). Globalization, a growing world population, climate change, migration etc. changes the context for global public health and produces new challenges to it (137). It becomes most obvious that these challenges must be undertaken by international agencies and organizations in collaborations with nation states and alliances of states like the EU (48, 138). As migration to a large extent is transnational to its character, so is also public health threats to a large extent transnational (139, 140).

Any health related intervention on either societal or individual level need to be based on evidence. As to global public health data, international organizations such as WHO play an important role (141). However, data is scarce on the most vulnerable groups of people at the margin of society, such as the core category of migrants dealt with in this research project, namely asylum seekers (142).

In Sweden, public health is developing positively for the population as a whole, but there are significant differences between various groups of the society. The gap between those who have the best and those with the worst health outcomes have also increased over the last decades (143). The social determinants of health outcome (18) play a significant role to this growing gap. As for certain groups of vulnerable migrants the negative mental health outcome is striking (124, 144).

The only systematic attempt by which the Swedish state has tried to identify health threats among migrants is to invite asylum seekers to a HA. However, the mental health sufferings among the asylum seekers does not get necessary attention and are, according to our data, overlooked. The HA were considered vital and were introduced in Sweden in the 1980s when migrants to a large extent arrived from areas where HIV and AIDS was common. The fear of HIV and AIDS at that time was massive and the HA has ever since, not least among the migrants, to a large extent been perceived merely as a check for HIV, which data from this research also confirm. This is unfortunate since the HA as such thus becomes linked to the stigma that HIV still is associated with. Similarly it is regrettable since the HA has a broader purpose.

The initial HA, as it is organized and carried out at present and as a major tool for identifying HIV in migrants can be questioned for several reasons. First, the access to the HA is confined primarily to asylum seekers, even though they are just a fraction of all migrants coming to Sweden. This also may be interpreted as if asylum seekers as a category of migrants, collectively is more susceptible to HIV than other categories of migrants. There are other migrants that may be much more susceptible to HIV, based on epidemiology in country of origin, sexual practice or injecting drug use. Second, far from all asylum seekers attend the HA, in fact only every other, as an average at national level. Data from this research show that asylum seekers view the HA with suspicions and may thus refrain from it since they are not sufficiently informed about the purpose of the HA. They also have questions and fear about a possible linkage between detection of diseases, for most part HIV, and how this may interfere with their asylum process. This fear is so strong that even among those having obtained a residence permit, fear of deportation remain, since that is what they think will happen if detected with HIV (145).

Conflicting policies and regulations

As illustrated in the modified access framework model (Figure 3), “access” represent different aspects and meanings and can be interpreted in different ways. In this section, I will discuss access from a policy perspective.

From this research project we have learned that asylum seekers are in a position where they have to navigate and make decisions, not knowing what the consequences will be, still with a strong sense that a wrong decision may result in deportation. They have to navigate, almost blindly, in a context of conflicting policies. Blindly, because the information they had was in their view not sufficient and the communication with authority's considered poor. The most obvious and crucial intersection for the informants of this study (21) was to be in, and to endure the asylum seeking process and at the same time being subjected to the Swedish healthcare, not knowing the link between the two authorities. The questions the asylum seekers seemed to be preoccupied with were, if attending the HA would be beneficial to their application for asylum or if a detection of a disease such as HIV would result in a negative outcome of the asylum seeking process and decision on the application. It seemed very clear that for the asylum seekers themselves the outcome of their asylum application was considered the far most important issue and their own health secondary. Knowing that the health status of the asylum seeker does not interfere with the outcome of the asylum application, it is unacceptable that this fact is not communicated in a sufficiently clear way, from the authorities to the applicants. This would have reduced feelings of fear, insecurity, ambiguity and mistrust and probably contributed to a higher HA coverage.

The content of the invitation to the HA is regulated by national guidelines that state that the invitation should include information on that the HA is optional (78). Ensuring asylum seekers autonomy in relation to the healthcare services reflects the importance this is given by Swedish authorities. The HA is, on the other hand, an important systematic attempt by which the authorities can control infectious diseases among asylum seekers in Sweden. Explicitly stressing the voluntariness contradicts this effort. Thus, this seems like a paradox that the authorities stress the importance to control infectious diseases in asylum seekers, but at the same time stress that it is not compulsory to participate. This contradiction becomes even more problematic when considering that, in no other part of the healthcare system, explicit information on voluntariness is expressed since the general principle in Sweden is that all healthcare, with few exceptions, is optional.

At times, critical comments are made on the concept "right to health", saying that no one can be assured health. However, the International Covenant on Social, Economic and Cultural rights (article 12) declares "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (10). Accordingly, this must be interpreted as there should be no discriminatory barriers in accessing healthcare services, in order for any human to enjoy the highest attainable standard of physical and mental health. This however, is not the same as being promised a life without illnesses.

Despite that the health of asylum seekers and refugees is a human rights concern protected by international law (10), when it comes to "Health for all" and "Universal health coverage", promoted by WHO (13, 43), crucial questions arises when these international policies are implemented by nation states. One such question is whether asylum seekers and other categories of migrants should have the right to access healthcare services on equal terms as the citizens of the host country. Any state having acknowledged these fundamental principles should not have the right to refrain from implementing universal access to healthcare for migrants as for the national citizens.

The Universal Declaration of Human Rights indicates both liberties and entitlements. The liberties include the right to control one´s health and body, as well as sexual and reproductive health and freedom (74) whilst the entitlements include the right to a health system that provides equal opportunities for everyone to enjoy the highest attainable level of health (10).

In this research project we wanted to find out if the HA offered to newly arrived asylum seekers materialize the right to health in the sense that by attending the HA it served the purpose of providing "an equal opportunity to enjoy the highest attainable level of health", given the vulnerable condition they were in.

UN already in year 1951 in the Refugee Convention had the ambition of reducing inequalities in health by emphasizing that refugees should enjoy access to health services equivalent to that of the host population (146). However, a question arises on what are the rights "equivalent to that of the host population" when it comes to asylum seekers? There is evidence to prove that when implemented into national policies and practices, the word "everyone" has many exceptions. As for asylum seekers it is common with restrictions, based on policy and regulations, on accessing healthcare on equal terms with the host population, among the EU-nations (85). Similarly, there varying practices among the member states as to screening for infectious diseases among newly arrived migrants (147). The EU has for 20 years been working on a Common European Asylum System (CEAS), where issues on health also are included, in order to improve the current legislative framework (148). It is well known that the creation of CEAS has not been an easy exercise and still there are many issues to be solved before such a common system is at place. However, in 2013 an updated Reception Conditions Directive was released and which sets out common minimum standards for the reception of asylum applicants for international protection across EU member states (149). In relation to health it is in article 13 stated that Member States may require medical screening for applicants on public health grounds. In article 19 it is stated that

1. Member States shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illnesses and of serious mental disorders.

2. Member States shall provide necessary medical or other assistance to applicants who have special reception needs, including appropriate mental health care where needed.

This may at first seem to be an acceptable rule with a humanistic approach. However, this is a restriction, supported officially by the EU, in its Minimum standards on the reception of applicants for asylum in Member States, updated in 2009 (150). In Art. 19 it states that asylum seekers must receive "the necessary health care which shall include, at least, emergency care and essential treatment of illness or mental disorders", but there are no words here on universal access or that asylum seekers have equal rights to enjoy the highest attainable level of health, as do the host population. If that had been the case there would have been no need for the EU to state "Minimum standards" for any categories of migrants.

The healthcare system and migrants

In this section I discuss access from the central parts of the modified access framework model (Figure 3) namely; accessibility, adequacy, acceptability, affordability, quality and utilization of healthcare services. The focus remains on that part of the healthcare system, the primary healthcare, responsible for the HA on migrants, the primary healthcare. Though the HA is at focus, the primary healthcare services beyond the HA is to a large extent also applicable in this context.

Besides formal barriers, such as restricted policies and laws that hinder asylum seekers from accessing healthcare services on equal terms as the general public, there are non-formal barriers to overcome, even within the frame of healthcare that is legitimately accessible to asylum seekers and other migrants. These non-legal barriers related to accessibility, adequacy, acceptability, affordability and quality may be as harmful to the migrants as the legal ones, since they may be less obvious and thus may exist without receiving enough attentions or being questioned.

In this research project we have identified two major issues that negatively influences *accessibility* and build barriers to the HA, offered to asylum seekers. First, it is a matter of communication, where poor communication on health related issues at different stages of the asylum seeking process have a negative impact on the accessibility to the HA. Data from this research show that poor communication is apparent already when the migration authority give initial information to

the asylum seekers on various matters, among them their right to a HA. Further, the informants reported poor or failed communication in relation to the actual invitation to the HA from the healthcare sector. One informant commented on this failure that she lost her chance to know about her health status. However, poor communication also reduces the likelihood of securing the public health purposes of the HA, namely detect contagious diseases that might be a threat to other people. Second, it is a matter of how the individual county council structures and organizes its healthcare in relation to the HA. Our data show a patchwork of different structures linked with varying coverage.

Though this research is not primarily on the content of the HA, there are however issues on *adequacy* in relation to the HA appearing in the data that need to be discussed. If the HA is not considered adequate and relevant it will undermine its legitimacy as an important instrument to secure the health of asylum seekers as well as securing the society's need for using HAs for public health reasons. The informants foremost considered the HA merely as a screening for HIV, at first based on what they had heard from their peers before attending the HA and later it was confirmed by their own experience. If this picture of the HA persist it is most likely that the HA will be viewed upon as less adequate. This is understandable, especially since most asylum seekers in recent years have come from countries where HIV is very rare. In contrast, many bring with them psychosomatic traumas for what they need immediate attention. However, if it is believed that the HA does not covers or recognizes such disorders, the HA will be looked upon as inadequate. Most regrettable however, data from this research also show that issues in relation to mental health is not prioritized in the HA and that psychological and psychiatric expertise capacity is not sufficient. Moreover, data from this research has also proven that there are other important issues, such as sexual health, that do not get adequate attention in connection with the HA.

Another barrier to overcome for the asylum seekers in relation to the HA is about *acceptability*. Data from this research reveal that the participants acknowledged the HA to be a good and reasonable offer, and thus acceptable. However, the way it is processed and carried out was on the contrary considered unacceptable. Data show that individual asylum seekers felt that they were not listened to, rather ignored, by the healthcare personnel. Their own perceived health needs and questions were not given a chance to elaborate on.

Affordability may to some, and under certain conditions, be a barrier to access healthcare. However, data from this research project does not reveal that lack of money in general would be a significant barrier for asylum seekers to attend the HA. Though the HA as such is free of charge for the asylum seeker there may be other barriers in relation to financial shortages, such as travel expenses. The strain on a small budget may vary a lot, depending on whether you are a single or

a family with several children. Also, it is a matter of the structure of the healthcare and the HA services in the particular county. In a county where there is a mobile health team, as described above under "accessibility", the travel cost for a single asylum seeker will probably be none. However, for a larger family, residing in a county where they have centralized the HAs to only one health center and that is far away, it might be considered not worthwhile to attend.

The last barrier to overcome, as illustrated in the access framework used (figure 3) is on *quality and utilization* of healthcare services. In this context it is about the quality of the HA and the coverage of the same, though correlations between these two cannot be proved based on this research.

Quality and quality assurance have increasingly become important in most part of society, and healthcare is no exception. While healthcare providers are striving to deliver quality healthcare services to their clients and patients, there are still uncertainties about how to define and to measure quality. There are many definitions, some more related to objective facts while others to more subjective feelings. However, they are interdependent. Øvretveit defines quality care as the 'provision of care that exceeds patient expectations and achieves the highest possible clinical outcomes with the resources available' (151) Another scholar, Schuster, define healthcare quality as "providing patients with appropriate services in a technically competent manner, with good communication, shared decision making and cultural sensitivity" (152).

The probably most well-known and respected scholar within this field is Avedis Donabedian, who defines healthcare quality as 'the application of medical science and technology in a manner that maximizes its benefit to health without correspondingly increasing the risk' (153). He also has developed a conceptual framework model for examining healthcare services and evaluating quality in the same. According to the model, information about quality of care can be drawn from three categories: "structure," "process," and "outcomes. Structure describes the context in which care is delivered, process has to do with the interactions between patients and healthcare providers and finally, outcomes refer to the effects that the healthcare service have on the patients.

The overall impression from data in the two studies where migrants shared their view, based on their own experiences of the HA, is that it is carried out with a low quality as to patient satisfaction. It is likely to think that this opinion is communicated in between the asylum seekers and other migrants and that it might have a negative influence on the readiness to participate in the HA.

Strengths and limitations of this research

The research group comprised experiences from policy, practice and research, in relation to migrants and health. Further it included individuals with different professions, experiences and skills.

Data were collected directly from former asylum seekers and thus no one talking on behalf of them.

One group of informants, former asylum seekers from Eritrea, were well defined.

This research was confined mainly to asylum seekers though other categories of migrants such as refugees, persons arriving on family reunification ground and undocumented immigrants and others are likely to have similar health related problems and needs for similar healthcare services, as asylum seekers.

The data collection for study I was conducted in 2010, which means that the results reflect the situation at that time. It is likely that policies and structures of the healthcare related to HAs for asylum seekers have changed, at least to some extent, since then. However, from the national statistics we can conclude that the proportion of asylum seekers undergoing HAs have not increased during this period of time.

Methodological considerations

The design of any study has its strengths and limitations. Similarly, the interpretation of research findings may be analyzed and interpreted in the light of the methods used. This thesis adopted a mixed method study design, at times referred to as triangulation, by applying both quantitative and qualitative techniques in the different studies.

The method chosen for study I was an exploratory quantitative descriptive design applying a cross-sectional survey based on two structured questionnaires. We found the method used to be appropriate to capture the views from both administrators and healthcare professionals in relation to the aim of the study, namely to identify variations in policies and implementation of HAs for asylum seekers and how organizational differences might influence the number of asylum seekers being assessed. Because the contents of the two questionnaires were thematically similar, this made it possible to analyze to what extent there was a congruence between the two groups of respondents. Although not, per definition, using a mixed method, the fixed response alternatives were complemented with a few open-ended questions that gave us a deeper understanding of the structure and procedures of the HAs.

The relatively high number of non-responders led to a thoughtful analysis of missing questionnaires, which were identified and explained as an over coverage. For some questions, a relatively large number of internal missing answers was seen. Further analysis showed that such questions might not have been clear enough or that the response alternative "Do not know" should have been provided in order to prove what we do suspect, namely that the missing values might represent the respondents´ inability to respond to the question rather than unwillingness to respond.

In study II a qualitative research design was applied using individual interviews. The informants had been selected purposively and thus statistical generalizations cannot be made from the findings. The constructed model could, however, be adjusted and used in similar situations for shaping policies, instructions and practice within the field of immigrant health, particularly when it comes to issues related to health assessments or screening programs targeting immigrants. The limitation due to language and translation was partly balanced by the use of a specially trained interpreter whose mother tongue is Tigrinya. Nevertheless, information might have been lost in the translation process. However, the rich description this study has presented still provides a valuable contribution to the knowledge base.

The method used in study III was the same as in study I, i.e. an exploratory quantitative descriptive design applying a cross-sectional survey based on two structured questionnaires. The participants in this study as well as in study II comprised of former asylum seekers. However, the research design was different, one qualitative and one quantitative. When analyzing the results we found that data from one study supported the other.

Conclusions

Despite public rhetoric favoring health as a human right and international policies being recognized by national Governments, declaring "Health for all" (43), "Health as a human right" (10), "Universal access" and "Universal health coverage" (13), "Equity" (5), "Leaving no one behind" (154) and more (39), when it comes to implementation and to apply these into practice, some of the most vulnerable groups of migrants, among them asylum seekers, are still left behind with restrictions and barriers on accessing HAs and other healthcare services.

When just analyzing policies, and maybe compare these with some other European countries, Sweden may appear as having a well-functioning healthcare system, caring for asylum seekers and other migrants. There is even a law saying that the county councils are obliged to invite all asylum seekers to a HA, which also may be seen as a guarantee for applying the notion of "health for all". However, when looking into coverage of the HA the picture look less positive, since only every other asylum seeker undergo the HA, with much differences between the 21 counties. Similarly, data from this research show much differences as to how the counties organize, allocate resources, carry out, follow up and ensure quality in relation to the HAs. The picture that emerges is that there is no coherent national system to secure health on equal terms for asylum seekers and other vulnerable migrants.

The HAs on asylum seekers has since long been a responsibility for the county councils and has for most part been carried out by dedicated nurses and GPs in the realm of primary healthcare. It is in this part of the healthcare system where the responsibility for the HAs ought to be also in the future, but structured and managed differently. It is my belief that the current fragmented system is not functioning well, to serve its purposes. Despite its weaknesses and poor outcome, I have in various talks and discussions defended our present "system" on health assessments for asylum seekers, because it is not all bad and that is what we have at present.

It is clear that the HIV-pandemic fueled the call for screening migrants in the 1980s, since at that time, many arrived from high endemic areas. Thus, the healthcare targeting asylum seekers is built on an assumption that asylum seekers are a risk to the host population and thus they need to be controlled for communicable diseases. Yet, the fact is that many migrants most at risk, for themselves and at times also to others, never get an invitation to a HA, since they do not belong to the "right" category of migrants.

Implications from this research on policy, practice and research

Implications on policy

Based on thinking, observing, discussing, researching and finally data from this research available, I would suggest a new policy on HAs, targeting asylum seekers, but also other migrants who would benefit from it.

Our present system is based on an idea that to undergo the HA should be of free will. I would argue that it should remain that way, partly since research data support that asylum seekers view the HA as a positive offer, though carried out in a less satisfactory way. There are no sound reasons to suggest a change to a compulsory HA, which at times have been proposed. Nor is it a need for, or a reason to explicit emphasize that the HA are voluntary, as stated in a national guideline on HA, since such remarks does not exists in other parts of the healthcare.

I would suggest a new "National Health Reception System", financed and secured by the state and targeting all immigrants coming to Sweden, no matter on what grounds. They should all be reached by a welcoming health-voucher, valid for a free visit at any general primary healthcare unit. This first visit, that to some would be the only one, should aim for a basic presentation of the Swedish healthcare system besides a health interview. It would then guide and decide any further action, based on needs and universal access. This health reception system should be totally separated from the migration authority, since the present rule where the migration authority give information on the HA has to some asylum seekers created worries on if the outcome of the HA may interfere with the asylum application.

Sweden has shown to be progressive and taken the lead in many areas that to some European and other countries would be considered a controversy. Of these, there are policies on defending human rights, for example child rights, migrant's rights, women's rights, LGBT-rights, SRHR, and gender equality. It is about time also to take a lead in a fair distribution of healthcare and lower migrants' barriers to access healthcare.

Finally, as policies that promotes health, when applied properly, can make a remarkable difference to migrants' life, so can policies that neglect health lead to the opposite. A recent comprehensive research, inspired by WHO's 'Health in All Policies', studied effects of non-health-targeted policies on migrants health (155). The conclusion was that restrictive entry and integration policies are linked to poor migrant health outcomes in high-income countries. Efforts to improve the

health of migrants would benefit from adopting a Health in All Policies perspective.

Implications on practice

Healthcare services targeting asylum seekers and other migrants ought to move away from being a parallel system to mainstream primary healthcare practice. If striving towards universal healthcare access we also need to stop acting as if "their health and ours" exist. Though most HAs on asylum seekers take place in ordinary health centers, it is common that asylum seekers HA and migrants healthcare other than HA is separated from mainstream healthcare for citizens and taken care of by specially allocated nurses and GPs. There are certainly advantages in doing so, but probably also disadvantages.

A robust sustainable primary healthcare must have the capacity it takes to serve all people living in the community, no matter who they are. Any nurse or GP working in primary healthcare should be equipped and able to see any individual in need for their services. In a primary healthcare setting, discriminatory actions should not be based on who you are as a person or what kind of migrant you are, but rather what health needs you might have. For example, one person need to see a GP, another need advice from a specialized diabetic nurse and another need to see a midwife. The latter, not because her country of origin is Ghana, but because she is pregnant.

Data from this research is clear on the excessive need for training of healthcare personnel in communication skills, which include cross cultural communication. Respectable communication builds trust and without it there will be no real encounters. In practice, there might be a list of compulsory topics to cover in the initial HA, but without asking the patient about self-perceived health needs the HA has failed. Further, some insight and knowledge in medical sociology and anthropology would benefit any nurse or GP working in a cross cultural setting.

Implications on research

There is in general lack of health data on migrants, which is very unfortunate for various reasons. Among them since it makes it difficult to target those in need for healthcare services. Even though around 50% of the asylum seekers in Sweden undergo the HA, there are still no aggregated health data available.

Study number one in this research project was about identifying variations in policies and implementation of HAs for asylum seekers in Sweden through analyses of structures and processes of HAs in different Swedish counties and discusses how this in turn might influence the coverage. This study could be referred to as

a baseline study, and a new similar study would add useful information on the progress and development of this part of the healthcare system.

Future research may, based on findings from this research, explore and analyze if, and if so, how, mobile healthcare may represent a positive alternative or complement to traditional stationary healthcare centers, in carrying out HAs on asylum seekers and increase the coverage.

If a shift from present policy and practice will take place in the near future it would be suitable and important to do an intervention research and follow the change and outcome of it.

Epilogue

Though not a breakthrough research, like any researcher, I wish that my contribution to the accumulated knowledge produced in this research will be well received and applied where suitable. Notwithstanding, this thesis is a product of a most rewarding learning exercise, carried out from wheat to bread.

I want to end this endeavor by expressing my hope and trust in mankind, to strive for a restored and secure common dwelling place for all. This can only come true by showing solidarity and implementing research data along with all the treaties, signed and ratified by States and authorities, at all levels of society around the globe. By so doing, we can together celebrate "the New Public Health" (156) materialized by the realization of "Health for all" (157).

Not long ago, on the 11th of December 2018, in Marrakech, Morocco, *the Global Compact for Migration,* the UN global agreement on a common approach to international migration in all its dimensions, was adopted (39), based on a resolution adopted by the General Assembly in 2016 (38). It comprises 23 objectives for better managing migration at local, national, regional and global levels. If implemented, it may have positive health implications on asylum seekers and other vulnerable groups of migrants.

Similarly, on the 15th of December 2018, the Global Climate UN – "COP24" in Katowice, Poland ended "in success", with a *global climate agreement* (158). If implemented, this will, in the long run, reduce the increasing numbers of forced migration due to climate change (137, 159).

Moreover, on the 15th December 2018 the UCL–*Lancet* Commission on Migration and Health: the health of a world on the move, was released. It gave those of us engaged in migrants health, in policy, practice or research, a gold mine of updated knowledge within this filed (160).

As if that was not enough, on the 18th December WHO released another important report: Report on the Health of Refugees and Migrants in the in the WHO European Region (64)

It is obvious that what this thesis is all about, migration and health, is high on the global agenda.

Just some few more words, to close this section

It happens to be that this dissertation takes place close to my upcoming retirement and end of service at the Public Health Agency of Sweden. Thus you may ask, like the grey-headed woman I heard some years ago being interviewed in a TV program in connection with her achievement of a Bachelor-degree, at the age of 70! The face of the young journalist revealed that he seemed to find it all very peculiar and odd. He said something like; - But, why did you… and then it was like if he hold back for a moment on what he maybe was about to say; - But, why did you do this academic endeavor now, at this stage of life, soon to die? No, he didn't say that. Actually he didn't find words to finish the sentence at all. Instead, the lady saved his face by saying; - To your surprise maybe, but this is just the beginning of what is ahead! Similarly, I end this section by paraphrasing - This is just the beginning of what is ahead!

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Appendices

Appendix 1. Questionnaire Healthcare personnel (Study I) (Swedish)

Appendix 2. Questionnaire Administrators (Study I) (Swedish)

Appendix 3. Interview guide (Study II) (English)

Appendix 4. Questionnaire (Study III) (English)

Enkät till hälso- och sjukvårdspersonal om hälsosamtal/hälsoundersökningar av asylsökande och anhöriginvandrade

Med *asyl- och flyktinghälsovård* avses den hälso- och sjukvårdsenhet (t ex vårdcentral) som genomför hälsoundersökningar av asylsökande, flyktingar, anhöriginvandrade och andra nyanlända med utländsk bakgrund.

Med *hälsosamtal* avses den del av hälsoundersökningen som begränsas till just ett samtal kring tidigare hälsa/ohälsa, sjukdomar, medicinering, vaccinationer, information om det svenska hälso- och sjukvårdssystemet etc

Med *hälsoundersökning* avses hälsosamtal, provtagning och annan undersökning

Med *Anhöriginvandrade* avses familjeanknytning som en sökande hänvisar till när han eller hon söker uppehållstillstånd. Denna undersökning begränsas till utlänning som har fått uppehållstillstånd på grund av sin anknytning till en utlänning och som ansökt om uppehållstillstånd inom två år från det att den person som han eller hon har anknytning till först togs emot i en kommun.

Med *landsting* avses i enkäten också *region* och *kommun*, där landsting inte finns.

Bakgrundsvariabler:

6 **Landsting:** .....

Kön?

☐ 1 Kvinna
☐ 2 Man
8

Profession/utbildning?

☐ 1 Läkare
☐ 2 Sjuksköterska
☐ 3 Annan, **Vilken?** .....
9

.....

Tjänstgör du som ...

☐ 1 Läkare
☐ 2 Sjuksköterska
☐ 3 Enhetschef/verksamhetschef med administrativ funktion
10

Har du någon särskild utbildning/fortbildning inom asyl- och flyktinghälsovård, internationell hälsa, migration eller motsvarande?

☐ 1 Ja
☐ 2 Nej
11

OM JA:

Ange vad och i vilken omfattning:

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.....

.....

Har du erfarenhet av hälso- och sjukvårdsarbete utanför Sverige?

☐ 1 Ja
☐ 2 Nej
12

OM JA:

Var?

☐ 1 Annat europeiskt land
☐ 2 Utomeuropeiskt land
13

Var är du född?

☐ 1 Sverige
☐ 2 Annat europeiskt land
☐ 3 Utomeuropeiskt land
14

Med vilka av följande ingår det i dina arbetsuppgifter att genomföra hälsosamtal/hälsoundersökningar?

		Ja (1)	Nej (2)
15	Asylsökande	☐	☐
16	Ensamkommande asylsökande barn	☐	☐
17	Anhöriginvandrade	☐	☐
18	Kvotflyktingar	☐	☐
19	Utländska adoptivbarn	☐	☐

Vad av följande ingår i dina arbetsuppgifter utöver att genomföra hälsosamtal/hälsoundersökningar?

		Ja (1)	Nej (2)
20	Annan hälso- och sjukvård för asylsökande	☐	☐
21	Administrativa arbetsuppgifter	☐	☐

OM ADMINISTRATIVA UPPGIFTER:

Vilka av följande arbetsuppgifter/ansvarsområden ingår?

Svara bara med sådana som relaterar till asyl- och flyktinghälsovården!

		Ja (1)	Nej (2)
22	Personaladministration	☐	☐
23	Administrativ stödfunktion	☐	☐
24	Stödfunktion i ekonomiska frågor	☐	☐
	Mottagare av person- och adress-uppgifter från Migrationsverket rörande nyanlända:		
25	asylsökande	☐	☐
26	ensamkommande asylsökande barn	☐	☐
27	anhöriginvandrade	☐	☐
	Mottagare av person- och adress-uppgifter från kommunen om nyanlända:		
28	ensamkommande asylsökande barn	☐	☐
29	anhöriginvandrade	☐	☐
	Att informera asyl- och flyktinghälso-vården om person- och		
30	adressuppgifter på nyanlända	☐	☐
	Att skicka ut kallelser till		
31	hälsoundersökning	☐	☐
	Att samla in uppgifter om antalet		
32	genomförda hälsoundersökningar	☐	☐
	Att återsöka pengar från staten/Migra-tionsverket för genomförda		
33	hälsoundersökningar	☐	☐

OM ADMINISTRATIVA UPPGIFTER:

Vilka av följande arbetsuppgifter/ansvarsområden ingår?

Svara bara med sådana som relaterar till asyl- och flyktinghälsovården!

		Ja (1)	Nej (2)
	Internekonomisk redovisning till landstinget för genomförda		
34	hälsoundersökningar	☐	☐
	Redovisning till Migrationsverket om genomförda hälsoundersökningar av ...		
		Ja	Nej
35	asylsökande	☐	☐
36	ensamkommande asylsökande barn	☐	☐
37	anhöriginvandrade	☐	☐
	Redovisning till SKL om antalet genomförda hälsoundersökningar av ...		
		Ja	Nej
38	asylsökande	☐	☐
39	ensamkommande asylsökande barn	☐	☐
40	anhöriginvandrade	☐	☐
	Information och fortbildning till hälso- och sjukvårdspersonal inom asyl-		
41	och flyktinghälsovården	☐	☐
42	Utfärda riktlinjer och styrdokument	☐	☐
43	Annat	☐	☐

OM ANNAT: **Vad?**

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Hur länge har du arbetat med hälsoundersökningar av asylsökande och anhöriginvandrade?

44 Antal år ☐☐

Hur stor andel av din tjänstgöring utgörs av hälsoundersökningar av asylsökande och anhöriginvandrade?

46 Procent ☐☐☐

Finns tillgång till handledning för den personal som är involverad i hälsoundersökningar av asylsökande och anhöriginvandrade?

☐ 1 Ja
☐ 2 Nej

49

OM JA:

Beskriv.

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Organisation:

Finns det på landstingsnivå en *stödfunktion (tjänst/kansli)* för asyl- och flyktinghälsovården?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

50

OM JA:

Beskriv.

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Finns det "spontana" informella nätverk och mötesplatser för personalen inom asyl- och flyktinghälsovården?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

51

OM JA:

Beskriv.

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Finns samverkan kring hälsoundersökningar över landstingsgränsen?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

52

OM JA:

Beskriv.

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Ange det som närmast beskriver den verksamhet du arbetar i.

☐ 1 Vårdcentral/hälsocentral
☐ 2 En särskild mottagning för asyl-/flyktinghälsovård på vårdcentral/ hälsocentral
☐ 3 Mottagning för enbart asyl-/flyktinghälsovård
☐ 4 Mobil mottagning/enhet

53

OM MOBIL MOTTAGNING/ENHET:

Beskriv .

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Verksamheten drivs i

☐ 1 Landstingets regi
☐ 2 Privat regi med landstingsavtal

54

Utförs hälsoundersökningar av anhöriginvandrade på samma enhet/mottagning som asylsökande?

☐ 1 Ja
☐ 2 Nej

55

OM NEJ:

Beskriv var hälsoundersökningar på anhörig-invandrare genomförs.

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Vad i ert landstings sätt att organisera asyl- och flyktinghälsovården utgör fördelar med avseende på att kunna genomföra en så hög andel hälsoundersökningar av *asylsökande* som möjligt?

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Vad i ert landstings sätt att organisera asyl- och flyktinghälsovården utgör fördelar med avseende på att kunna genomföra en så hög andel hälsosamtal/hälsoundersökning av *anhöriginvandrade* som möjligt?

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Vilka nackdelar finns med er organisation av asyl- och flyktinghälsovården, som bidrar till att *asylsökande* inte genomgår hälsosamtal/hälsoundersökning i önskvärd utsträckning?

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Vilka nackdelar finns med er organisation av asyl- och flyktinghälsovården, som bidrar till att *anhöriginvandrade* inte genomgår hälsosamtal/hälsoundersökning i önskvärd utsträckning?

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Kompetenser:

Vilka av följande professioner/kompetenser finns tillgängliga för asylsökande på din mottagning utan remissförfarande?

Ange om de finns tillgängliga per telefon, på plats eller både per telefon och på plats.
Ange också för var och en av de tillgängliga professionerna om tillgången är tillräcklig eller otillräcklig.

		Per telefon	På plats	Både på plats o.per telefon	Till-räckligt	Otill-räckligt
56	Barnläkare	☐	☐	☐	☐	☐
58	Psykiatriker	☐	☐	☐	☐	☐
60	Gynekolog/obstetriker	☐	☐	☐	☐	☐
62	Ortopedläkare	☐	☐	☐	☐	☐
64	Annan specialistläkare, **Vad?**	☐	☐	☐	☐	☐
	.....					
66	Distriktssjuksköterska	☐	☐	☐	☐	☐
68	Barnsjuksköterska	☐	☐	☐	☐	☐
70	Barnmorska	☐	☐	☐	☐	☐
72	Psykiatrisjuksköterska	☐	☐	☐	☐	☐
74	Psykoterapeut/psykolog	☐	☐	☐	☐	☐
76	Kurator	☐	☐	☐	☐	☐
78	Tandläkare/tandhygienist/tandsköterska	☐	☐	☐	☐	☐
80	Dietist	☐	☐	☐	☐	☐
82	Annan, **Vad?**	☐	☐	☐	☐	☐
	.....					

Finns skriftliga riktlinjer rörande remittering av patient?

84
- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Vet ej

OM JA:

Bifoga riktlinjerna eller skicka dem till undersokning@skop.se.

Begrepp och dess tillämpning i verksamheten:

		Ja (1)	Nej (2)
85	Begreppet *hälsosamtal* används synonymt med *hälsoundersökning*	☐	☐
86	Begreppen hälsosamtal och hälso-undersökning har olika betydelse	☐	☐
87	Vi använder endast begreppet hälsosamtal	☐	☐
88	Vi använder endast begreppet hälsoundersökning	☐	☐
89	Hälsosamtalet utgör en del av hälsoundersökningen	☐	☐
90	Med hälsoundersökning avser vi hälsosamtal, provtagning och annan undersökning	☐	☐
91	Vi utför endast hälsosamtal	☐	☐
92	Vi utför hälsoundersökningar, inte endast hälsosamtal	☐	☐

Kommentar:

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Förekommer begreppet "*vård som inte kan anstå*" i samband med hälsoundersökning av *asylsökande*?

- ☐ 1 Mycket ofta
- ☐ 2 Ibland
- ☐ 3 Sällan
- ☐ 4 Aldrig

93

Ge exempel och beskriv en situation när begreppet aktualiseras:

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Finns skriftliga riktlinjer i din verksamhet som förtydligar begreppet "*vård som inte kan anstå*"?

- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Vet ej

94

OM JA:

Bifoga kopia/kopior av riktlinjer/styrdokument. Om dessa finns elektroniskt kan de istället skickas med e-post till undersokning@skop.se.

Beskriv hur begreppet ska tolkas och tillämpas enligt dessa.

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På vilket sätt påverkas verksamheten med asylsökande av att detta begrepp har definierats?

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Om det finns skriftliga riktlinjer i din verksamhet som tolkar och klargör hur "*Vård som inte kan anstå*" ska tillämpas, vem/vilken funktion har utfärdat dessa?

- ☐ 1 Centralt på landstinget
- ☐ 2 Verksamhetschefen
- ☐ 3 Annan, **Vem?** .....
- ☐ 4 Vet ej

95

OM NEJ:

Hur tolkas och tillämpas detta begrepp på din mottagning?

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På vilket sätt påverkas verksamheten med asylsökande av att detta begrepp inte har definierats?

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Har du erfarenhet av att *asylsökande* inte remitterats vidare för sjukdomstillstånd som inte var akut, men som obehandlat på sikt sannolikt skulle få allvarliga negativa hälsokonsekvenser?

- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Vet ej

96

OM JA:

Ge exempel på ett sådant sjukdomstillstånd.

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Bedömer du det sannolikt att en person med uppehållstillstånd/svensk medborgare skulle ha remitterats vidare under samma omständigheter?

- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Vet ej

97

Finns behov av att utföra undersökningar, provtagningar, vård och behandlingsinsatset som inte kan erbjudas asylsökande pga verksamhetens ekonomiska begränsningar?

- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Nej
- ☐ 4 Vet ej

98

Kommentar

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Verksamhetsstyrning:

Finns det *landstingsövergripande* skriftliga riktlinjer/styrdokument för asyl-/flyktinghälsovården?

99
- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Vet ej

OM JA:

Bifoga kopia/kopior av riktlinjer/styrdokument. Om dessa finns elektroniskt kan de istället skickas med e-post till undersokning@skop.se

Finns det *lokalt utformade* skriftliga riktlinjer/styrdokument för asyl- och flyktinghälsovården?

100
- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Vet ej

OM JA:

Bifoga kopia/kopior av riktlinjer/styrdokument. Om dessa finns elektroniskt kan de istället skickas med e-post till till undersokning@skop.se

Finns skriftliga riktlinjer för hälsoundersökningens genomförande?

101
- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Vet ej

OM JA:

Används dessa riktlinjer vid hälsoundersökningen?

102
- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Till viss del
- ☐ 4 Vet ej

För vilka av följande kategorier finns särskilt utformade riktlinjer?

		Ja (1)	Nej (2)
103	Vuxna kvinnor	☐	☐
104	Vuxna män	☐	☐
105	Barn	☐	☐
106	Ungdomar	☐	☐
107	Utländska adoptivbarn	☐	☐
108	Gravida	☐	☐

Bifoga de riktlinjer som finns för hälsoundersökningens genomförande. Om dessa finns elektroniskt kan de istället skickas med e-post till till undersokning@skop.se

Anser du det önskvärt att riktlinjer för hälsoundersökningar utformas så att samma riktlinjer kom att gälla för både asylsökande barn och *utländska adoptivbarn*?

109
- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Vet ej

Kommentar:

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Anser du att det saknas/finns behov av *skriftliga riktlinjer/vägledande dokument* som idag inte tillgodoses inom asyl- och flyktinghälsovården?

110
- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Vet ej

OM JA:

Inom vilket eller vilka områden?

		Ja (1)	Nej (2)
111	På nationell nivå	☐	☐
112	På landstingsnivå	☐	☐
113	På lokalnivå	☐	☐

Kommentar om på nationell nivå:

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Kommentar om på landstingsnivå:

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Kommentar om på lokal nivå:

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Anser du att det saknas/finns behov av *styrande dokument* (regelverk i form av lagar, förordningar och föreskrifter) som idag inte tillgodoses för asyl- och flyktinghälsovården?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

114

OM JA:

Ange inom vilket/vilka områden.

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Information och kommunikation

Vem lämnar upplysningar till *asylsökande* om deras rätt till en hälsoundersökning?

		Ifylles ej
☐	1 Polismyndigheten	☐
☐	2 Migrationsverket	☐
☐	3 Landstingets kansli	☐
☐	4 Asyl- och flyktinghälsovården	☐
☐	5 Annan, **Vem?**	☐
☐	6 Vet ej	☐

115-120

Vem lämnar upplysningar till *ensamkommande asylsökande barn* om deras rätt till en hälsoundersökning?

		Ifylles ej
☐	1 Polismyndigheten	☐
☐	2 Migrationsverket	☐
☐	3 Landstingets kansli	☐
☐	4 Kommunens flyktingsamordnare	☐
☐	5 Asyl- och flyktinghälsovården	☐
☐	6 Annan, **Vem?**	☐
☐	7 Vet ej	☐

121-127

Vem lämnar upplysningar till *anhöriginvandrade* om deras rätt till en hälsoundersökning?

		Ifylles ej
☐	1 Ambassaden	☐
☐	2 Migrationsverket	☐
☐	3 Landstingets kansli	☐
☐	4 Kommunens flyktingsamordnare	☐
☐	5 Asyl- och flyktinghälsovården	☐
☐	6 Annan, **Vem?**	☐
☐	7 Vet ej	☐

128-134

Dokumenteras att den asylsökande/anhöriginvandrade blivit informerad om rätten till en hälsoundersökning?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

135

Kommentar:

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Hur får primärvården/asyl- och flyktinghälsovården information om *asylsökande* som ska inbjudas till hälsoundersökning?

		Ja (1)	Nej (2)
136	Migrationsverket *centralt* skickar personuppgifter till landstinget centralt som sedan informerar asyl- och flyktinghälsovården	☐	☐
137	Migrationsverket *lokalt/regionalt* skickar personuppgifter till landstinget centralt som sedan informerar asyl- och flyktinghälsovården	☐	☐
138	Migrationsverket *centralt* skickar personuppgifter direkt till asyl- och flyktinghälsovården	☐	☐
139	Migrationsverket *lokalt/regionalt* skickar personuppgifter direkt till asyl- och flyktinghälsovården	☐	☐
140	Annat, **Beskriv**	☐	☐

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Hur får primärvården/asyl- och flyktinghälsovården information om *anhöriginvandrad* som ska inbjudas till hälsoundersökning?

		Ja (1)	Nej (2)
141	Migrationsverket *centralt* skickar personuppgifter till landstinget centralt som sedan informerar asyl- och flyktinghälsovården	☐	☐
142	Migrationsverket *lokalt/regionalt* skickar personuppgifter till landstinget centralt som sedan informerar asyl- och flyktinghälsovården	☐	☐
143	Migrationsverket *centralt* skickar personuppgifter direkt till asyl- och flyktinghälsovården	☐	☐
144	Migrationsverket *lokalt/regionalt* skickar personuppgifter direkt till asyl- och flyktinghälsovården	☐	☐
145	Migrationsverket skickar personuppgifter till *kommunen* som sedan informerar primärvården/asyl- och flyktinghälsovården	☐	☐
146	Annat, **Beskriv**	☐	☐

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Hur sker inbjudan till hälsosamtal/hälsoundersökning?

		Ja (1)	Nej (2)
147	Skriftligt på svenska	☐	☐
148	Skriftligt på engelska	☐	☐
149	Skriftligt på mottagarens modersmål	☐	☐
150	Muntligt på engelska	☐	☐
151	Muntligt på annat språk med tolk	☐	☐
152	Både skriftligt och muntligt	☐	☐

Framgår det av inbjudan att hälsoundersökningen är frivillig?

☐ 1 Ja
☐ 2 Nej
153

Upprepas inbjudan om personen inte kommer på erbjuden tid?

☐ 1 Ja
☐ 2 Nej
154

OM JA:

Beskriv hur och hur många gånger inbjudan upprepas.

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Vilken betydelse har asylsökandes boendeform för antalet genomförda hälsoundersökningar?

☐ 1 Anläggningsboende leder till ett ökat antal som genomgår hälsoundersökning
☐ 2 Eget boende leder till ökat antal som genomgår hälsoundersökning
☐ 3 Boendeformen har ingen avgörande betydelse för antalet asylsökande som genomgår hälsoundersökning
155

Kommentar:

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Utförs hälsoundersökningar vid din mottagning på andra än asylsökande och anhöriginvandrade?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej
156

OM JA:

Vilka av följande?

		Ja (1)	Nej (2)
157	Papperslösa	☐	☐
158	Kvotflyktingar	☐	☐
159	Anhöriginvandrad som har fått uppehållstillstånd pga anknytnig till en svensk och för vilken staten (Migrationsverket) inte betalar för hälsoundersökningen	☐	☐
160	Adoptivbarn	☐	☐
161	Andra, **Vilka?**	☐	☐

.....

Hur säkerställs patientens identitet vid hälsoundersökning på *asylsökande*?

		Ja (1)	Nej (2)
162	Muntligt, utan ID-handling	☐	☐
163	LMA-kort	☐	☐
164	Pass	☐	☐
165	Annan ID-handling	☐	☐

Kommentar:

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Hur säkerställs patientens identitet vid hälsoundersökning på *anhöriginvandrad*?

		Ja (1)	Nej (2)
166	Muntligt, utan ID-handling	☐	☐
167	Pass	☐	☐
168	Annan ID-handling	☐	☐

Kommentar:

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Hälsoundersökningens innehåll och genomförande:

Nu följer ett antal påståenden. Markera det svar som mest motsvarar din uppfattning.

		Tar helt avstånd från (1)	Tar delvis avstånd från (2)	Instämmer delvis (3)	Instämmer helt (4)
169	**Jag har den kompetens som behövs för att på ett tillfredsställande sätt utföra mina arbetsuppgifter inom asyl- och flyktinghälsovården**	☐	☐	☐	☐
170	**Verksamhetens riktlinjer tillämpas i sin helhet på ett tillfredsställande sätt**	☐	☐	☐	☐
171	**Vi har välfungerande kallelserutiner som sannolikt bidrar till ett högt antal genomförda hälsoundersökningar**	☐	☐	☐	☐
172	**Det inledande hälsosamtalet sker alltid individuellt**	☐	☐	☐	☐
173	**Hälsosamtalet sker utifrån ett standardiserat schema/checklista**	☐	☐	☐	☐
174	**Hälsosamtalet följer samma struktur och innehåll för kvinnor och män**	☐	☐	☐	☐
175	**Genomförandet av hälsosamtal/-undersökningar styrs mer av den aktuella asylsökandes/anhöriginvandrades behov och den bedömning jag gör i det enskilda fallet än av riktlinjer och styrdokument**	☐	☐	☐	☐
176	**Genomförandet av hälsosamtal/-undersökningar följer huvudsakligen fasta riktlinjer och genomförs som regel mer standardiserat än individanpassat**	☐	☐	☐	☐
177	**Provtagning sker utifrån ett standardiserat schema/checklista**	☐	☐	☐	☐
178	**Vid hälsoundersökningen utförs regelmässigt tuberkulintestning (PPD)**	☐	☐	☐	☐
179	**Hälsoundersökningen genomförs alltid med tolk när personen inte kan svenska eller engelska**	☐	☐	☐	☐
180	**Vid användandet av tolk sker detta som regel genom telefon**	☐	☐	☐	☐
181	**I samband med hälsoundersökningen ges information om den svenska hälso- och sjukvården**	☐	☐	☐	☐
182	**Betydelsen av hälsoundersökningar av asylsökande och anhöriginvandrade är överskattat**	☐	☐	☐	☐
183	**Vid hälsoundersökningar på fertila kvinnor görs regelmässigt bedömningar av vaccinationsstatus**	☐	☐	☐	☐
184	**Vid hälsoundersökningar på fertila kvinnor erbjuds vid behov vaccination mot Röda hund**	☐	☐	☐	☐
185	**Gravida kvinnor som genomgår hälsoundersökning remitteras alltid till Mödravårdscentral**	☐	☐	☐	☐
186	**Vid hälsoundersökningar på barn görs regelmässigt bedömningar av vaccinationsstatus**	☐	☐	☐	☐
187	**Vid hälsoundersökningar finns alltid läkare eller sjuksköterska med behörighet att ordinera vaccinationer tillgänglig**	☐	☐	☐	☐

Nu följer ytterligare ett antal påståenden. Markera det svar som mest motsvarar din uppfattning.

		Tar helt avstånd från (1)	Tar delvis avstånd från (2)	Instämmer delvis (3)	Instämmer helt (4)
188	**Uppgifter om vaccinationsstatus hos förskolebarn förmedlas rutinmässigt till barnhälsovården (BVC)**	☐	☐	☐	☐
189	**Uppgifter om vaccinationsstatus hos skolbarn förmedlas rutinmässigt till skolhälsovården**	☐	☐	☐	☐
190	**Vid hälsoundersökningar ställs som regel frågor rörande personens sexuella hälsa (preventivmedel/kondomer, graviditet, omskärelse, sexuellt våld/tvång etc.)**	☐	☐	☐	☐
191	**Vid hälsoundersökningen förs som regel samtal om HIV och STI och hur dessa infektioner kan förebyggas**	☐	☐	☐	☐
192	**Det finns tillgång till kondomer för utdelning/försäljning på mottagningen**	☐	☐	☐	☐
193	**Det finns informationsbroschyrer om HIV och STI på mottagningen**	☐	☐	☐	☐
194	**Vid hälsoundersökningar av asylsökande och anhörig-invandrade görs som regel HIV-test**	☐	☐	☐	☐
195	**Vid hälsoundersökningar använder vi s.k. ”snabbtest” för HIV**	☐	☐	☐	☐
196	**Vid HIV-test förekommer regelmässigt strukturerade ”reflekterande samtal” kring förebyggande av HIV och STI**	☐	☐	☐	☐
197	**Det finns strukturerade rutiner för den fortsatta hand-läggningen om någon diagnostiseras HIV-positiv**	☐	☐	☐	☐
198	**Min erfarenhet är att asylsökande som är i behov av remiss till specialistvård får det**	☐	☐	☐	☐
199	**Hälsoundersökningen av vuxna asylsökande leder ofta till etiska dilemman för personalen på grund av att sjukdomar och ohälsa diagnostiseras som personen har begränsad rätt att få behandling för**	☐	☐	☐	☐

Asyl- och flyktinghälsovården bemannas av ...

☐ 1 Enbart sjuksköterska/or
☐ 2 Enbart läkare
☐ 3 Både av sjuksköterska och läkare
☐ 4 Huvudsakligen av sjuksköterska, men vid behov även av läkare
☐ 5 Huvudsakligen av läkare, men vid behov även av sjuksköterska

200

***Hälsosamtal* genomförs som regel av ...**

Ifylles ej

☐ 1 Sjuksköterska ☐
☐ 2 Läkare ☐
☐ 3 Annan ☐

201-203

***Hälsoundersökning* genomförs som regel av ...**

Ifylles ej

☐ 1 Sjuksköterska ☐
☐ 2 Läkare ☐

204-205

Hälsosamtal/-undersökning görs sammanhållet av ...

Ifylles ej

☐ 1 Sjuksköterska ☐
☐ 2 Läkare ☐

206-207

Kommentar:

.....

.....

Ange hälsoundersökningens huvudsakliga fokus genom att rangordna fem av alternativen nedan med siffror 1 – 5, där 1 = högsta prioritet.

- ☐ Psykisk ohälsa
- ☐ Somatiska akuta tillstånd
- ☐ Kroniska tillstånd
- ☐ Hiv-infektion
- ☐ STI
- ☐ Andra infektionssjukdomar
- ☐ Trauma och våld
- ☐ Annat, **Vad?** .....
- ☐ Inget särskilt prioriterat fokus finns.

208-216

Anser du att det saknas/finns behov av *metodstöd* som idag inte tillgodoses inom asyl- och flyktinghälsovården?

- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Vet ej

217

OM JA:

Inom vilket eller vilka områden?

På nationell nivå:

.....

.....

.....

På landstingsnivå:

.....

.....

.....

På lokal nivå:

.....

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.....

Resultat/uppföljning

Hur lång bedömer du den genomsnittliga tiden är från att asyl- och flyktinghälsovården fått information om en nyanländ *asylsökande* till hälsoundersökningen genomförs?

- ☐ 1 1 månad eller mindre
- ☐ 2 Mer än 1 men högst 2 månader
- ☐ 3 Mer än 2 månader
- ☐ 4 Vet inte

218

Hur lång är den genomsnittliga tiden från att *anhörig-invandrade* flyttat till Sverige till att information om personen når asyl- och flyktinghälsovården?

- ☐ 1 1 vecka eller mindre
- ☐ 2 Mer än 1 vecka men högst 1månad
- ☐ 3 Mer än 1 men högst 2 månader
- ☐ 4 Mer än 2 månader
- ☐ 5 Vet inte

219

Hur lång uppskattar du den genomsnittliga tiden är från att asyl- och flyktinghälsovården fått information om en nyanländ *anhöriginvandrad* till hälsoundersökningen genomförs?

- ☐ 1 1 vecka eller mindre
- ☐ 2 Mer än 1 vecka men högst 1månad
- ☐ 3 Mer än 1 men högst 2 månader
- ☐ 4 Mer än 2 månader
- ☐ 5 Vet inte

220

Finns rutiner som möjliggör uppföljning av totalt antal genomförda hälsoundersökningar av asylsökande under ett kalenderår?

- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Vet ej

2121

Finns rutiner som möjliggör uppföljning av antal genomförda hälsoundersökningar på din mottagning i relation till antal nyanlända *asylsökande* som tilldelats mottagningen?

- ☐ 1 Ja
- ☐ 2 Nej
- ☐ 3 Vet ej

222

OM JA:

Ange i hur stor omfattning hälsoundersökningar genomfördes av nyanlända *asylsökande* som tilldelats mottagningen under föregående år?

- ☐ 1 Mindre än 25 procent
- ☐ 2 25-49 procent
- ☐ 3 50-74 procent
- ☐ 4 75-100 procent
- ☐ 5 Vet inte

223

Finns rutiner som möjliggör uppföljning av antal genomförda hälsoundersökningar i relation till antal nyanlända *anhöriginvandrade* under föregående år?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

224

OM JA:

Ange i hur stor omfattning hälsoundersökningar genomfördes av nyanlända *anhöriginvandrade* inom din mottagnings upptagningsområde under föregående år?

☐ 1 Mindre än 25 procent
☐ 2 25-49 procent
☐ 3 50-74 procent
☐ 4 75-100 procent
☐ 5 Vet inte

225

Görs systematiska uppföljningar om varför personer som fått inbjudan avböjt eller uteblivit från hälsoundersökning?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

226

OM JA:

Sammanfatta orsakerna från den senaste uppföljningen.

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Övrig relevant information som saknas i frågorna ovan

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Tack för hjälpen!

Enkät till kontaktpersoner (administratörer) i landstingen för asyl- och flyktingfrågor om hälsosamtal/hälsoundersökningar av asylsökande och anhöriginvandrade

Med *asyl- och flyktinghälsovård* avses den hälso- och sjukvårdsenhet (t ex vårdcentral) som genomför hälsoundersökningar av asylsökande, flyktingar, anhöriginvandrade och andra nyanlända med utländsk bakgrund.

Med *hälsosamtal* avses den del av hälsoundersökningen som begränsas till just ett samtal kring tidigare hälsa/ohälsa, sjukdomar, medicinering, vaccinationer, information om det svenska hälso- och sjukvårdssystemet etc

Med *hälsoundersökning* avses hälsosamtal, provtagning och annan undersökning

Med *Anhöriginvandrade* avses familjeanknytning som en sökande hänvisar till när han eller hon söker uppehållstillstånd. Denna undersökning begränsas till utlänning som har fått uppehållstillstånd på grund av sin anknytning till en utlänning och som ansökt om uppehållstillstånd inom två år från det att den person som han eller hon har anknytning till först togs emot i en kommun.

Med *landsting* avses i enkäten också *region* och *kommun*, där landsting inte finns.

Bakgrundsvariabler:

6 **Landsting:** .....

Kön?

☐ 1 Kvinna
☐ 2 Man
7

Profession?

☐ 1 Administratör
☐ 2 Ekonom
☐ 3 Annan, **Vilken?** .....
8

.....

Tjänstgör du som ...

☐ 1 Administratör
☐ 2 Ekonom
☐ 3 Annat, **Vad?** .....
9

Var är du född?

☐ 1 Sverige
☐ 2 Annat europeiskt land
☐ 3 Utomeuropeiskt land
10

Har du någon särskild administrativ utbildning/fortbildning i relation till asyl- och flyktinghälsovård, migration eller motsvarande?

☐ 1 Ja
☐ 2 Nej
11

OM JA:

Ange vad och i vilken omfattning:

.....

.....

.....

Har du erfarenhet av hälso- och sjukvårdsadministrativt arbete utanför Sverige?

☐ 1 Ja
☐ 2 Nej
12

OM JA:

Var?

☐ 1 Annat europeiskt land
☐ 2 Utomeuropeiskt land
13

Hur länge har du arbetat med administrativa/ekonomiska frågor som relaterar till hälsoundersökningar av asylsökande/anhöriginvandrade?

14 Antal år ☐☐

Hur stor andel av din tjänstgöring utgörs av administrativa/ekonomiska frågor som relaterar till verksamhet där hälsoundersökningar av asylsökande och/eller anhöriginvandrade genomförs?

16 Procent ☐☐☐

Organisation:

Finns det på landstingsnivå en *stödfunktion (tjänst/kansli)* för asyl- och flyktinghälsovården?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej
19

OM JA:

Beskriv stödfunktionen.

.....

.....

.....

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Vilka av följande kompetensområden finns representerade i denna funktion?

		Ja (1)	Nej (2)
20	Administartiv	☐	☐
21	Ekonomisk	☐	☐
22	Juridisk	☐	☐
23	Medicinsk-/vård	☐	☐
24	Annan, Vad?	☐	☐

.....

OM JA, (STÖDFUNKTION PÅ LANDSTINGSNIVÅ, FORTS.):

Vilka av följande arbetsuppgifter/ansvarsområden ingår i denna funktion?

Svara bara med sådana som relaterar till asyl- och flyktinghälsovården!

		Ja (1)	Nej (2)
25	Personaladministration	☐	☐
26	Administrativ stödfunktion	☐	☐
27	Stödfunktion i ekonomiska frågor	☐	☐
	Mottagare av person- och adress-uppgifter från Migrationsverket rörande nyanlända:		
28	asylsökande	☐	☐
29	ensamkommande asylsökande barn	☐	☐
30	anhöriginvandrade	☐	☐
	Mottagare av person- och adress-uppgifter från kommunen om nyanlända:		
31	ensamkommande asylsökande barn	☐	☐
32	anhöriginvandrade	☐	☐
	Att informera asyl- och flyktinghälso-vården om person- och		
33	adressuppgifter på nyanlända	☐	☐
	Att skicka ut kallelser till		
34	hälsoundersökning	☐	☐
	Att samla in uppgifter om antalet		
35	genomförda hälsoundersökningar	☐	☐
	Att återsöka pengar från staten/Migra-tionsverket för genomförda		
36	hälsoundersökningar	☐	☐
	Internekonomisk redovisning till landstinget för genomförda		
37	hälsoundersökningar	☐	☐
	Redovisning till Migrationsverket om genomförda hälsoundersökningar av ...		
38	asylsökande	☐	☐
39	ensamkommande asylsökande barn	☐	☐
40	anhöriginvandrade	☐	☐
	Redovisning till SKL om antalet genomförda hälsoundersökningar av ...		
41	asylsökande	☐	☐
42	ensamkommande asylsökande barn	☐	☐
43	anhöriginvandrade	☐	☐
	Information och fortbildning till hälso- och sjukvårdspersonal inom asyl-		
44	och flyktinghälsovården	☐	☐
45	Utfärda riktlinjer och styrdokument	☐	☐
46	Annat	☐	☐

OM ANNAT: **Vad?**

.....

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Om någon/några av arbetsuppgifterna istället, helt eller delvis, utförs på mottagning som utför hälsoundersökningar av asylsökande och anhöriginvandrade, svara nedan.

		Ja (1)	Nej (2)
47	Personaladministration	☐	☐
48	Administrativ stödfunktion	☐	☐
49	Stödfunktion i ekonomiska frågor	☐	☐
	Mottagare av person- och adress-uppgifter från Migrationsverket rörande nyanlända:		
50	asylsökande	☐	☐
51	ensamkommande asylsökande barn	☐	☐
52	anhöriginvandrade	☐	☐
	Mottagare av person- och adress-uppgifter från kommunen om nyanlända:		
53	ensamkommande asylsökande barn	☐	☐
54	anhöriginvandrade	☐	☐
	Att informera asyl- och flyktinghälso-vården om person- och		
55	adressuppgifter på nyanlända	☐	☐
	Att skicka ut kallelser till		
56	hälsoundersökning	☐	☐
	Att samla in uppgifter om antalet		
57	genomförda hälsoundersökningar	☐	☐
	Att återsöka pengar från staten/Migra-tionsverket för genomförda		
58	hälsoundersökningar	☐	☐
	Internekonomisk redovisning till landstinget för genomförda		
59	hälsoundersökningar	☐	☐
	Redovisning till Migrationsverket om genomförda hälsoundersökningar av ...		
60	asylsökande	☐	☐
61	ensamkommande asylsökande barn	☐	☐
62	anhöriginvandrade	☐	☐
	Redovisning till SKL om antalet genomförda hälsoundersökningar av ...		
63	asylsökande	☐	☐
34	ensamkommande asylsökande barn	☐	☐
35	anhöriginvandrade	☐	☐
	Information och fortbildning till hälso- och sjukvårdspersonal inom asyl-		
66	och flyktinghälsovården	☐	☐
67	Utfärda riktlinjer och styrdokument	☐	☐
68	Annat	☐	☐

OM ANNAT: **Vad?**

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.....

.....

Finns administrativ samverkan över landstingsgränsen av asyl- och flyktinghälsovården?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

69

OM JA:

Beskriv samverkan.

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Vid hur många enheter (vårdcentraler/hälsocentraler/ asylhälsovårdsmottagningar) i landstinget/regionen utförs hälsoundersökningar av asylsökande och anhörig-invandrade?

☐ 1 1 enhet
☐ 2 2 – 3 enheter
☐ 3 4 – 10 enheter
☐ 4 Fler än 10 enheter

70

Ange nedan hur antalet hälsoundersökningar fördelades mellan de fem mottagningar i ditt landsting som genomförde flest hälsoundersökningar under år 2009, samt antalet hälsoundersökningar på övriga mottagningar sammantaget.

	Namn på mottagning	Mottagning i landstingets regi	Mottagning i privat regi med landstings-avtal	Antal hälso-under-sökningar av asyl-sökande	Antal hälso-under-sökningar av anhörig-invandrade
71-80	1.	☐	☐		
81-90	2.	☐	☐		
91-100	3.	☐	☐		
101-110	4.	☐	☐		
111-120	5.	☐	☐		
121-130	Samtliga övriga mottagningar inom landstinget/regionen	------	------		
131-140	Totalt antal				

Verksamheten för hälsoundersökningar sker i ...

☐ 1 Landstingets regi
☐ 2 Privat regi med landstingsavtal
☐ 3 Både landstingets och privat regi

141

Vad i ert landstings sätt att organisera asyl- och flyktinghälsovården ger särskilda fördelar med avseende på att kunna genomföra en så hög andel hälsoundersökningar av *asylsökande* som möjligt?

.....

.....

.....

.....

Vad i ert landstings sätt att organisera asyl- och flyktinghälsovården ger särskilda fördelar med avseende på att kunna genomföra en så hög andel hälsosamtal/hälsoundersökning av *anhöriginvandrade* som möjligt?

.....

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Vilka nackdelar finns med er organisation av asyl- och flyktinghälsovården, som bidrar till att *asylsökande* inte genomgår hälsosamtal/hälsoundersökning i önskvärd utsträckning?

.....

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.....

Vilka nackdelar finns med er organisation av asyl- och flyktinghälsovården, som bidrar till att anhöriginvandrade inte genomgår hälsosamtal/hälsoundersökning i önskvärd utsträckning?

.....

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Verksamhetsstyrning

Finns det *landstingsövergripande riktlinjer/styrdokument* för asyl-/flyktinghälsovården?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

142

OM JA:

Bifoga kopia/kopior av riktlinjer/styrdokument. Om dessa finns elektroniskt kan de istället skickas med e-post till undersokning@skop.se

Finns ett systematiskt *kvalitetssäkringsarbete* av hälsoundersökningar för asylsökande och anhöriginvandrade?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

143

OM JA:

Beskriv.

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Finns systematisk *metodutveckling* av hälsoundersökningar för asylsökande och anhöriginvandrade?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

144

OM JA:

Beskriv.

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Anser du att det saknas/finns behov av *metodstöd* som idag inte tillgodoses inom asyl- och flyktinghälsovårdens administrativa/ekonomiska del?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej
145

OM JA:

Inom viket/vilka områden?

På nationell nivå:

.....

.....

.....

På landstingsnivå:

.....

.....

.....

På lokal nivå:

.....

.....

.....

Anser du att det saknas/finns behov av *riktlinjer/vägledande dokument* som idag inte tillgodoses inom asyl- och flyktinghälsovårdens administrativa/ekonomiska del?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej
146

OM JA:

Inom viket/vilka områden?

På nationell nivå:

.....

.....

.....

På landstingsnivå:

.....

.....

.....

OM JA (FORTS.):

På lokal nivå:

.....

.....

.....

Nu följer ett antal påståenden. Markera det svar som mest motsvarar din uppfattning.

Statens (Migrationsverkets) ersättningar till landstinget för hälsoundersökningar av asylsökande och anhörig-invandrade baseras på antalet nyanlända asylsökande och anhöriginvandrare

☐ 1 Tar helt avstånd från
☐ 2 Tar delvis avstånd från
☐ 3 Instämmer delvis
☐ 4 Instämmer helt
147

Statens (Migrationsverkets) ersättningar till landstinget för hälsoundersökningar av asylsökande och anhörig-invandrade baseras på antalet kallelser/inbjudna till hälsoundersökningar

☐ 1 Tar helt avstånd från
☐ 2 Tar delvis avstånd från
☐ 3 Instämmer delvis
☐ 4 Instämmer helt
148

Statens (Migrationsverkets) ersättningar till landstinget för hälsoundersökningar av asylsökande och anhörig-invandrade baseras på antalet genomförda hälsoundersökningar

☐ 1 Tar helt avstånd från
☐ 2 Tar delvis avstånd från
☐ 3 Instämmer delvis
☐ 4 Instämmer helt
149

Statens (Migrationsverkets) ersättningar till landstinget för hälsoundersökningar av asylsökande och anhörig-invandrade baseras på omfattningen av/innehållet i hälsoundersökningen

☐ 1 Tar helt avstånd från
☐ 2 Tar delvis avstånd från
☐ 3 Instämmer delvis
☐ 4 Instämmer helt
150

Migrationsverket informerar rutinmässigt landstinget om person- och kontaktuppgifter på nyanlända asylsökande, som behövs för att kunna fullgöra de skyldigheter landstinget har rörande hälsoundersökningar av asylsökande

☐ 1 Tar helt avstånd från
☐ 2 Tar delvis avstånd från
☐ 3 Instämmer delvis
☐ 4 Instämmer helt

151

Landstinget har nödvändiga samverkansrutiner (med Migrationsverket och/eller kommunen) för att erhålla person- och kontaktuppgifter på nyanlända anhöriginvandrade, för att kunna erbjuda hälsoundersökning till dem som har rätt till en kostnadsfri sådan.

☐ 1 Tar helt avstånd från
☐ 2 Tar delvis avstånd från
☐ 3 Instämmer delvis
☐ 4 Instämmer helt

152

Vi har välfungerande kallelserutiner som sannolikt bidrar till ett högt antal genomförda hälsoundersökningar

☐ 1 Tar helt avstånd från
☐ 2 Tar delvis avstånd från
☐ 3 Instämmer delvis
☐ 4 Instämmer helt

153

Resultat/uppföljning:

Hur lång uppskattar du att den genomsnittliga tiden var under år 2009, från att *asylsökande* sökt asyl till att informationen nådde landstinget om att personen skulle kallas till hälsoundersökning?

☐ 1 1 vecka eller mindre
☐ 2 Mer än 1 vecka men högst 1månad
☐ 3 Mer än 1 men högst 2 månader
☐ 4 Mer än 2 månader
☐ 5 Vet inte

154

Hur lång uppskattar du att den genomsnittliga tiden var under år 2009, från att landstinget informerats om en nyanländ *asylsökande* till att denna information nådde asyl- och flyktinghälsovården?

☐ 1 1 vecka eller mindre
☐ 2 Mer än 1 vecka men högst 1månad
☐ 3 Mer än 1 men högst 2 månader
☐ 4 Mer än 2 månader
☐ 5 Vet inte

155

Finns rutiner som möjliggör uppföljning av totalt antal genomförda hälsoundersökningar under ett kalenderår?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

156

OM JA:

Ange hur många hälsoundersökningar som genomfördes inom landstinget/regionen under år 2009 på

157-161 ☐☐☐☐☐ asylsökande
162-166 ☐☐☐☐☐ ensamkommande asylsökande barn
167-171 ☐☐☐☐☐ anhöriginvandrade

Finns rutiner som möjliggör uppföljning av antal genomförda hälsoundersökningar i relation till antal nyanlända *asylsökande* under ett kalenderår?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

172

OM JA:

Ange i hur stor omfattning hälsoundersökningar genomfördes av nyanlända *asylsökande* inom landstinget som helhet under år 2009?

☐ 1 Mindre än 25 procent
☐ 2 25-49 procent
☐ 3 50-74 procent
☐ 4 75-100 procent
☐ 5 Vet inte

173

Finns rutiner som möjliggör uppföljning av antal genomförda hälsoundersökningar i relation till antal nyanlända *anhöriginvandrade* under ett kalenderår?

☐ 1 Ja
☐ 2 Nej
☐ 3 Vet ej

174

OM JA:

Ange i hur stor omfattning hälsoundersökningar genomfördes av nyanlända *anhöriginvandrade* inom landstinget som helhet under år 2009?

☐ 1 Mindre än 25 procent
☐ 2 25-49 procent
☐ 3 50-74 procent
☐ 4 75-100 procent
☐ 5 Vet inte

175

Fortsättning och slut på nästa sida!

Eventuell övrig relevant information som saknas i frågorna ovan:

.....

.....

.....

.....

.....

.....

.....

.....

.....

Tack för hjälpen!

Robert Jonzon, 2013.

Thematic guide for interviews with former asylum seekers from Eritrea and their views on health assessments offered to newly arrived asylum seekers in Sweden.

• The time before you came to Sweden ...
When you or someone else in your family got sick in your home country, how did you manage that? Was it common that you received professional treatment by a doctor or nurse or did you commonly cure yourself at home, without the involvement of a doctor or nurse? Did you use any medicine without the doctor prescribing it? If so, where did you get these medicines from and what kind of drug was it?

What experience do you have from healthcare in your home country? When you sought healthcare and treatment at a clinic / health center / hospital in your home country, how was it? Did you feel that you were helped and that you were satisfied, or? What was good and what do you think was less good?

What experience do you have from preventive and health-promoting healthcare in your home country? For example, how to protect yourself from illnesses, infections and other ill-health. Further, by vaccinating and avoiding tobacco and drug abuse, but also how to improve your health by, for example, eating nutritious foods.

Do you have experience of health assessments, without it being caused by disease symptoms, in your home country? How do you view preventive healthcare in general? Is it in your view anything good, unnecessary, important or something that you find difficult to have an idea about?

• About your time in Sweden ...
How did you experience the first encounter with a healthcare in Sweden? How did it happen? Was it on your own initiative, or were you invited for some special reason? Tell me, please! Were you satisfied or not? Tell me, please! What was good and what was not so good?

Do you remember when and by whom you received information that you were entitled to a free health assessment during the time of your asylum process? Tell me, please!

Have you received an invitation to a health assessment during the time of your asylum process? If yes, how long after you arrived in Sweden did you receive the invitation? How did you get it? Did you understand the invitation? Was it clear? In what language was the invitation written? Did the notice contain information about the purpose of the assessment? Did you perceive the invitation as a voluntary offer or as a compulsory directive?

In what way would you prefer the invitation to the health assessment being communicated? For example; by a verbal personal invitation, by a phone call, a letter, e-mail, sms etc.

Did you talk to other asylum seekers about their experience of the health assessment before you had your own health assessment carried out? What information did you get from them and what stand did they recommend you to take?

Did you ever have doubts about agreeing to accept the invitation? Why? Please, tell me what you felt and about your thoughts! For example, did you feel worried that any discovery of disease or infection would adversely affect the asylum process?

If you accepted the invitation and went through the health assessment, what expectations did you have for the health assessment? Tell me, please!

What did the health assessment contain? Was it just a health interview? What examinations were made? Did they take any blood samples and other laboratory samples? Tell me, please!

Did you already know before you went for the health assessment that HIV tests are done routinely in connection with the health assessment of asylum seekers? Did this affect you in any way when you were about to decide to take part or to abstain from the health assessment?

Do you know if you had a HIV-test carried out in connection with your health assessment? How did you experience that? How and when did you get a message about the outcome of the HIV test?

Did you get any information, oral and / or written, in connection with the test on how to protect yourself against HIV and other sexually transmitted infections? What are your thoughts about the appropriateness that such information are given in connection with the health assessment? Please, tell me what you think about this.

Who conducted the health assessment, a doctor and / or a nurse? How did you experience it? Did it work well?

Was an interpreter present during the health assessment? How did you experience it? Did it work well?

How did you experience the health assessment at large? Did the health assessment meet your expectations and health needs?

In connection with your health assessment, did you receive information about the rights and restrictions you as an asylum seeker have regarding healthcare in Sweden? If not, what do you know about your rights and restrictions in this matter?

Do you feel that you after the health assessment had more knowledge about where, when and how to navigate when you are in need for seeking healthcare in Sweden?

Can you tell me something that was particularly <u>good</u> in connection with the health assessment?

Can you tell me something that was particularly <u>bad</u> in connection with the health assessment?

Describe your confidence in the Swedish healthcare? Compare with experiences from your home country.

Have you told any asylum seeker who has not undergone a health assessment about your own experiences from it? What did you say? Did you recommend to undergo the health assessment, or?

If you did not accept the invitation for a health assessment, tell me why you refused. There may be one or more reasons.

If you have not received an invitation to the health assessment, what do you think about that, knowing that you have the right to a health assessment, free of charge? Do you feel that you have missed something important, or do you feel like it does not matter?

Is there anything you would like to clarify, change or add to what we've been talking about so far? Would you like to ask something before moving on?

In the beginning, we talked about how you did in your home country when you or someone in the family got sick. We spoke about what you did on your own, “self-care”? Did you try to cure and treat yourself or family members, for example, with medications without first seeking medical attention? What do you think about that now, when you are in Sweden? Has your way of acting in connection

with illnesses changed in comparison to your behavior before you came to Sweden, and if so, how?

Anything to add? If there is anything else you want to say or add something you were missing in this conversation, then there is an opportunity to do this now.

Summarize! Awaiting confirmation that everything is correctly understood

To conclude, a word of thanks for the contribution of a valuable conversation. Say; It is our hope and belief that your contribution and sharing of experiences and views will benefit and help to achieve the goals and objectives of this research. Thank you very much!

Hi!

Do you want to participate in a study?

This study is about the right to health for immigrants in Sweden. It is aimed to persons who recently have come here and probably have been invited to a free health examination. We want to know what you think about the health examination and your experience of it, if you had one done.

The objective of the study is to highlight your perceptions and experiences of the health examination and the Swedish health care system.

You can participate in the study by answering this questionnaire. Participation is voluntary, but your opinion is important in order to improve health examinations and to get more people attending the examination.

No personal information that may reveal your identity is requested. Your answers will be grouped with those of other participants, in order to secure secrecy.

If you do not understand a question, ask for support from the person in charge of the survey. If you consider a question to be sensitive and that you do not want to answer it, you may just leave it behind and go to the next question.

Finally, we want to emphasise that your participation is very important and that you contribution will make this study more valuable. If you still do not want to participate in the study; please, return the questionnaire to the person in charge.

Thanks a lot for your collaboration.

Best regards,

Lubin Lobo

HEALTH EXAMINATIONS AND THE RIGHT TO HEALTH OF IMMIGRANTS RECENTLY ARRIVED

Instructions:

Your answers will be scanned in a machine. For that reason we ask you:

- Use a blue or black pen, NOT a pencil
- Mark your answers with an X, in this way: ☒ but not like in this: 
- If you want to change an answer, fill the box that went wrong: ■ and make a new X in the right one.: ☒
- Write numbers clearly when requested. Write only one number in each box, like this:

1	2	3	4

- Write clear texts in the indicated boxes when explanations are requested or when you want to provide additional information.
- Please, do not write out side of the boxed.

HEALTH EXAMINATIONS AND THE RIGHT TO HEALTH OF IMMIGRANTS RECENTLY ARRIVED

Initially some questions about you and your background

1. In what year were you born?

In 19 ☐☐

2. Are you a woman or a man?

☐ Woman ☐ Man

3. In which country were you born?

☐ Somalia ☐ Afghanistan ☐ Iraq
☐ Syria ☐ Eritrea ☐ Thailand

☐ In another country. Which one? _____

4. What year did you come to Sweden?

Year ☐☐☐☐

5. When did you obtain residence permission in Sweden?

Year ☐☐☐☐

6. What is your civil status?

☐ Married ☐ Living with partner ☐ Singel

☐ Divorced ☐ Widow(er)

7. Do you have children?

☐ Yes, and they live in Sweden
☐ Yes but they live in another country
☐ No, I do not have children

8. What level of education do you have?

☐ None
☐ 1 – 6 years (Primary school)
☐ 7-12 years (Secondary school)
☐ more than 12 years (High school /University)
☐ Other kind of education, what? _____

9. What is your religion?

- ☐ I am not a religious person
- ☐ I am a Muslim
- ☐ I am a Christian
- ☐ I am a Buddhist
- ☐ I have another religion. Which? _____

10. For what reason did you come to Sweden?

- ☐ To apply for asylum.
- ☐ To live with my parents/ family who came earlier to appy for asylum here.
- ☐ To live with / marry a Swede
- ☐ To live with / marry a non-Swedish European living in Sweden
- ☐ To work in Sweden
- ☐ For another reason, what? _____

Questions about the life in your home country

This questions help us to understand how you lived **the last year** in your home country.

11. What did you mainly do during the last year in your home country?

Mark only one alternative.

- ☐ I worked
- ☐ I did domestic work
- ☐ I was unemployed
- ☐ I did something else, what? _____
- ☐ I studied
- ☐ I was a farmer

12. Did you and your family have enough money ...

Mark the alternative that best applies to you in each line.

	Yes, always	Yes, sometimes	Yes, sometimes
a. To buy food?	☐	☐	☐
b. To pay school fee and school materials?	☐	☐	☐
c. To pay for health care?	☐	☐	☐

13. How often did you go to consult a doctor (or a nurse), during the last year in your home country?

- ☐ Never
- ☐ In one ocassion
- ☐ More than one ocassion

14. Did you or your family suffered from violence or threats in your home country?

☐ Yes ☐ No ☐ I do not know

15. Did you come to Sweden with your family?

- ☐ Yes, I came here with my family.
- ☐ Yes, I came here with some members of my family.
- ☐ No, I came here alone.

Questions about your first period in Sweden

16. How did you mainly live <u>during the first six months</u> in Sweden?

Mark only <u>one alternative.</u>

- ☐ With other asylum seekers (in a special place for refugees and asylum seekers)
- ☐ With other unaccomapnied children (in an institutions or special place for these children)
- ☐ With family or relatives (at their place)
- ☐ With friends från my country
- ☐ With other persons, who:

17. <u>During your first six months</u> in Sweden...

Mark the alternative that best applies to you in each line.

	Yes, always	Yes, sometimes	No, never
a. Did you have someone who could help with, e.g. contacts with authorities, addresses/find places, translate texts or explain instructions?	☐	☐	☐
b. Did you have someone to talk to about your feelings or personal problems?	☐	☐	☐
c. Did you feel alone or isolated?	☐	☐	☐

18. a. How was your health <u>during the first three months</u> in Sweden?

- ☐ Very well
- ☐ Well
- ☐ Not well, nor bad
- ☐ Bad
- ☐ Very bad

b. Did you need some kind of medical care during the first three months in Sweden?

- ☐ Yes
- ☐ No → **Move to question 19**
- ☐ I do not remember → **Move to question 19**

c. If you answered <u>Yes</u>, what kind of medical care did you need?

- ☐ Due to pregnancy
- ☐ Due to flu
- ☐ Due to chronic desease (e.g. Diabetes)
- ☐ Due to other illness or injury
- ☐ Due to mental desease (e.g. anxiety, depression)
- ☐ Due to an infection (e.g. tuberculosis (TB), HIV/AIDS, Hepatitis)
- ☐ For another reason,which?
- ☐ I do not know

d. Did you get some treatment or care?

- ☐ Yes
- ☐ No
- ☐ I do not know

About health and health care

19. Your ideas about health

Mark the alternative in each line that best applies to you.

	Agree	Disagree	I don't know
a. I can feel bad even if I do not have any disease	☐	☐	☐
b. A person can be sick but feel OK.	☐	☐	☐
c. I can do nothing to influence my own health.	☐	☐	☐
d. God decides about my sickness or health.	☐	☐	☐
e. What I do and how I live have an impact on my health	☐	☐	☐
f. To see a doctor and getting medicines are most important when I am sick.	☐	☐	☐
g. I prefer other alternatives than doctors and medicines when I am sick	☐	☐	☐
h. Illness can be a consequence of sin, magic or evil spirits.	☐	☐	☐

20. Your perceptions about the health care

Mark the alternative in each line that best applies to you.

	Yes	No	I don't know
a. I had better health care services in my country than in Sweden	☐	☐	☐
b. I cannot get here the medicines that doctors would get me in my country.	☐	☐	☐
c. I thrust more to physicians and nurses in my country than I do here.	☐	☐	☐
d. I visit a doctor only if I am seriously sick.	☐	☐	☐
e. For me, physicians should to be of the same sex as myself	☐	☐	☐
f. I avoid talking about sexuality and intimate things, even if the doctor asks me about it.	☐	☐	☐
g. I know where to seek care if I get sick.	☐	☐	☐
h. Physicians in Sweden do not understand my health problems.	☐	☐	☐

21. What source of information is most important for you in relation to food and habits considered good for health?

- ☐ Health care services in Sweden (e.g. doctor, nurse, dietician)
- ☐ Health care in your home country
- ☐ Schools and other institutions for education in Sweden (e.g. SFI)
- ☐ Schools in your home country
- ☐ Media (e.g. TV, internet, books, brochures, posters)
- ☐ Providers of free time activities (e.g. organizations, associations)
- ☐ Relatives and friends
- ☐ Other, specify what:

Questions about health examinations

These questions are about a health examination that new arrivals are offered for free when they come to Sweden, whether healthy or sick. Usually one is invited to the health examination shortly after arrival in Sweden. At the health examination the doctor or nurse often ask about vaccinations, previous illnesses and doing medical tests.

22. Have you ever before heard of health examinations for new arrivals?

- ☐ Yes
- ☐ No → **Move to question 27**

23. From whom did you receive information about the health examination?

You may mark several alternatives.

- ☐ Swedish Migration Board
- ☐ Health care
- ☐ Family, relatives or friends
- ☐ I found the information myself about the health examination.
- ☐ I have not found any information about the health examination. .
- ☐ Others, who?

24. Did you get a letter of invitation to health examination?

- ☐ Yes
- ☐ No → **Move to question 27**

25. a. In what language was the invitation written?

You may mark several alternatives..

- ☐ Swedish
- ☐ English
- ☐ Other language, what?
- ☐ Do not know

b. Did you understand the content?

- ☐ Yes
- ☐ Partly
- ☐ No
- ☐ No, but someone helped me to translate
- ☐ I do not remember

26. What information did you get in the invitation to the health examination?

Mark the alternative that best applies to you in each line.

	Yes	No	Do not remember
a. The purpose of the health examination	☐	☐	☐
b. How the health examination is carried out	☐	☐	☐
c. That the health examination is optional	☐	☐	☐
d. How I could find the way to the health center	☐	☐	☐
e. That the result from the health examination will not be communicated with the Swedish Migration Board	☐	☐	☐

27. In what way would you prefer to receive the invitation to the health examination?

☐ Orally
☐ Written on paper (letter, brochure etc.)
☐ Written on the Internet.
☐ By a telephone call
☐ SMS sent to my mobile phone
☐ On radio
☐ In another way, what way?

28. What do you think the purpose of the health examination is?

Mark the alternative that best applies to you in each line.

	Yes	No	Do not know
a. To check whether I was healthy or sick	☐	☐	☐
b. To offer care or treatment if I was sick.	☐	☐	☐
c. To identify communicable diseases (e.g. TB, HIV, AIDS, hepatitis)	☐	☐	☐
d. To protect the society from communicable diseases that I may have.	☐	☐	☐
e. To vaccinate and protect me from diseases that might be present in the society	☐	☐	☐
f. To identify if I was fit to start to work	☐	☐	☐
g. To give me information about health issuesr	☐	☐	☐
h. To prevent diseases.	☐	☐	☐

i. Other, What?

29. Did you undergo the health examination?

☐ Yes
☐ No → **Move on to question 42**

30. When did you do the health examination?

- ☐ Less than 1 year ago
- ☐ Between 1 and 2 year ago
- ☐ More than 2 years ago

31. Where did you do the health examination?

- ☐ Stockholm
- ☐ Skåne
- ☐ Östergötland
- ☐ Norrbotten
- ☐ Other place, Where?

32. Why did you do the health examination?

Mark the alternative that best applies to you in each line.

	Yes	No	I do not know
a. It was free of cost.	☐	☐	☐
b. I thought it was compulsory.	☐	☐	☐
c. I wanted to stay in Sweden	☐	☐	☐
d. I was pregnant	☐	☐	☐
e. I was sick and needed health care.	☐	☐	☐
f. I wanted to know if I had any disease.	☐	☐	☐
g. I wanted to know if I had any communicable disease.	☐	☐	☐
h. I needed to talk with someone regarding my health	☐	☐	☐
i. Other persons recommended the health examination	☐	☐	☐

j. Other reason?

33. What expectations did you have regarding undergoing the health examination?

Mark the alternative that best applies to you in each line.

	I agree	I disagree	I do not know
a. It would increase my chance to stay in Sweden	☐	☐	☐
b. To get a diagnos.	☐	☐	☐
c. To get treatment and medicine	☐	☐	☐
d. I had no particular expectations	☐	☐	☐

e. If you had other expectations. What?

34. Who did the health examination?

- ☐ A doctor
- ☐ A nurse
- ☐ Both a doctor and a nurse
- ☐ Do not know
- ☐ Do not remember

About the communication with the doctor or the nurse.

35. When you talked to the doctor o the nurse at the health examination...

Mark the alternative that best applies to you in each line.

	Yes	Partly	No	Do not remember
a. Were you informed on what tests that were done and why?	☐	☐	☐	☐
b. Did you understand the doctor or the nurse?	☐	☐	☐	☐
c. Do you think the doctor or the nurse understood what you were saying?	☐	☐	☐	☐
d. Were your questions answered?	☐	☐	☐	☐
e. Were you satisfied with the answers?	☐	☐	☐	☐
f. Did you get a chance to express your health concerns in a satisfactory way?	☐	☐	☐	☐
g. Did you get any advice regarding your health concerns?	☐	☐	☐	☐
h. Did you get any treatment or medicin?	☐	☐	☐	☐
i. Was there anything you had wanted to talk about during the health examination but did not get a chance to?	☐	☐	☐	☐

j. If **yes** on the last question, what?

About the content of the health examination

36. During the health examination...

Mark the alternative that best applies to you in each line.

	Yes	No	Do not remember	Do not know
a. Did the doctor or the nurse do a physical examination?	☐	☐	☐	☐
b. Was any medical tests done?	☐	☐	☐	☐
c. Did you get information on what tests that were done?	☐	☐	☐	☐
d. Did you get information on why the tests were done?	☐	☐	☐	☐
e. Did you get the results?	☐	☐	☐	☐

Interpreters

An interpreter is a person who helps with translations when the patient does not speak the same language as the doctor or the nurse.

37. a. Did you have an interpreter at your health examination?

- ☐ Yes
- ☐ No → **Move on to question 38**

b. Were the interpreter present in the clinic or on the telephone?

- ☐ In the clinic
- ☐ On the telephone

c. Did you know the interpreter?

- ☐ Yes, the interpreter was a relative
- ☐ Yes, the interpreter was a friend
- ☐ No, I did not know the interpreter

d. What would you prefer?

- ☐ An interpreter that I know
- ☐ An interpreter that I do not know.
- ☐ Either, it does not matter

e. Was the interpreter of the same sex as you?

- ☐ Yes
- ☐ No
- ☐ I do not know

f. Do you think the interpreter ought to be of the same sex as you?

- ☐ Yes
- ☐ No
- ☐ Either, it does not matter

g. Did you trust the interpreter to translate what you said in a correct way?

- ☐ Yes
- ☐ No

h. How did it work to communicate using an interpreter?

- ☐ It worked well
- ☐ Not well, nor bad
- ☐ Bad
- ☐ Do not know

i. What do you think is the best?

- ☐ To have the interpreter in the room at the health examination
- ☐ To have the interpreter via the telephone

About the right to health

38. Did the doctor or the nurse explain to you any of the following?

Mark the alternative that best applies to you in each line.

	Yes	No	Do not remember
a. That only asylum seekers have the right to the health examination.	☐	☐	☐
b. That it is optional to undergo the health examination.	☐	☐	☐
c. That adult asylum seekers have limited access to health care in Sweden.	☐	☐	☐
d. Those asylum seekers under the age of 18 have the same right to health care as all children in Sweden.	☐	☐	☐
e. What service you may get from the health care.	☐	☐	☐
f. Where you can get health care service if you get sick.	☐	☐	☐
g. Where you may get help if you are feeling very sad, stressed or not being able to sleep.	☐	☐	☐
h. How you protect yourself (or your partner) from an unwanted pregnancy.	☐	☐	☐
i. How you protect yourself from sexually transmitted infections (e.g. HIV/AIDS, Chlamydia och gonorrhea)	☐	☐	☐
j. How to act to reduce the risk to get TB.	☐	☐	☐

39. Your reflection from having done the health examination...

Mark the alternative that best applies to you in each line.

	Yes	Partly	No	Do not remember
a. Did the health examination make you feel better?	☐	☐	☐	☐
b. Did you get information that make you feel better and prevent disease?	☐	☐	☐	☐
c. Did you trust the person who carried out the health examination?	☐	☐	☐	☐
d. Did the health examination correspond to your expectations?	☐	☐	☐	☐
e. Are you over all satisfied with the health examination?	☐	☐	☐	☐
f. Do you think that the doctor or nurse treated you in a respectful manner?	☐	☐	☐	☐
g. Did you feel insulted or derogated in connection to the health examination?	☐	☐	☐	☐

h. If **yes** on the last question, in what way;

40. **If you were treated well and satisfied with the health examination → Move to 41**

If you were <u>not</u> treated in a good or respectful way at the health examination, what do you think was the reason to this?

Mark the alternative that best applies to you in each line.

	Yes	No	Do not know/ no opinion
a. My language problems / limitations	☐	☐	☐
b. My nationality or ethnic identity	☐	☐	☐
c. My sex	☐	☐	☐
d. My age	☐	☐	☐
e. For being disable or handicapped	☐	☐	☐
f. My religion	☐	☐	☐
g. My colour of skin	☐	☐	☐
h. My sexual orientation	☐	☐	☐

h. Other reason;

41. After the health examination, I feel...

☐ More positive towards the health examination than before.
☐ More negative towards the health examination than before.
☐ Whether more positive or negative

If you did the health examination, go directly to question 44

To you who did NOT do the health examination

42. Why did you <u>not</u> do the health examination?

Mark the alternative that best applies to you in each line.

	Agree	Do not agree	Do not know
a. I was not a asylum seeker	☐	☐	☐
b. I had never heard about the health examination	☐	☐	☐
c. I have not received a letter or invitation	☐	☐	☐
d. I received an invitation but did not want to go	☐	☐	☐
e. I did not understand what the health examination was	☐	☐	☐
f. I thought the health examination may have negative effect on my asylum application	☐	☐	☐
g. I thought I would not get the medicines I needed	☐	☐	☐
h. I do not like to talk about my health problems och difficulties	☐	☐	☐
i. I felt healthy	☐	☐	☐
j. I am afraid of syringes and injections	☐	☐	☐
k. I have bad experiences from contacts with the Swedish Migration Board	☐	☐	☐
l. I have bad experiences from contacts with doctors and nurses in Sweden	☐	☐	☐
m. I was afraid that I had a dangerous disease	☐	☐	☐
n. I did not want to know that I had HIV/AIDS	☐	☐	☐
o. I was afraid for what others might say if I had HIV/AIDS	☐	☐	☐
p. I did not want to know if I had tuberculosis (TB)	☐	☐	☐
q. I was afraid for what others might say if I had tuberculosis (TB)	☐	☐	☐
r. I have heard negative comments on the health examination	☐	☐	☐
s. I was afraid for having to leave Sweden if I was seriously sick	☐	☐	☐
t. Because others I know had not done the health examination	☐	☐	☐

u. Other reason;

43. Do you think of any negative effect by <u>not</u> having done the health examination?

☐ Yes. If so, what?
☐ No
☐ Do not know

Your advices to others in relation to the health examination

44. Would you recommend other persons to do the health examination?

- ☐ Yes
- ☐ No
- ☐ No opinion

Questions regarding your present health status

45. How do you perceive your general health condition during the last three months in Sweden?

- ☐ Very good
- ☐ Good
- ☐ Not good, nor bad
- ☐ Bad
- ☐ Very bad

46. How do you perceive your general health condition in comparison with others in your own age?

- ☐ Better
- ☐ Worse
- ☐ About the same

47. Have you during the last three months been in need for a doctor or seeking health care, but refrained from doing so?

- ☐ Yes
- ☐ No → **Go to question 49**

48. Why did you not go to see a doctor?

- ☐ My problems disappeared
- ☐ Too long waiting time
- ☐ Difficult to get in contact by the telephone
- ☐ Negative experiences from before
- ☐ I did not know where to go or who to ask
- ☐ For economic reasons
- ☐ I did not have the time to go
- ☐ Because of language difficulties
- ☐ Other reason, what?

About answering the questionnaire

S ENGELSKA | L | ID

49. How did you answer the questionnaire?

- ☐ I have read by myself and answered the questions in written.
- ☐ Someone read the questions for me and I have then answered the questions in written.
- ☐ Someone read the questions for me and also written the answers according to what I told.

50. Where did you answer the questionnaire?

- ☐ In Stockholm county
- ☐ In Norrbottens county
- ☐ In Östergötlands county
- ☐ In Skåne county

51. Do you have any comments to add?

Thank you very much for your cooperation!