THE SAHLGRENSKA ACADEMY

Healthcare seeking behaviours among Immigrants in Sweden.

A literature review

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Examiner: Anders Carlsten

English Title: Healthcare seeking behaviours among immigrants in Sweden

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ABSTRACT

Background: Healthcare seeking behaviours among immigrants in Sweden is a public health issue since the health outcome not only affects immigrants but also the Swedish population, the healthcare system and impacts on the national economy. In order to alleviate the problems and support the development of health among immigrants we need a thorough picture of the situation today.

Objectives: To explore the healthcare seeking behaviours of immigrants in Sweden looking at the different epidemiological reasons and challenges faced during healthcare seeking and the support than can be appropriate for combating the challenges.

Method: Literature based study. The methods and designs applied in the articles were assessed and graded on method strength by STROBE, Malterud guidelines and GRADE respectively.

Result: 15 articles were identified through a systematic search and used to determine the quality and strength of the scientific methods used to explore the questions of the study. Reasons for seeking health care were signs and symptoms, communicable as well as non-communicable diseases, among those mental health issues. Obstacles to seeking health care were cultural background as well as perception of causes of diseases and language barriers; in addition, the organisation of care and the attitudes among providers were also seen as obstacles to seeking healthcare.

Conclusion: Health seeking behaviour among immigrants vary according to ethnic backgrounds as pertains to diseases and beliefs. However, the challenges faced are common among the different groups and they range from cultural social economic to health illiteracy and language barriers.

Key Words: Healthcare seeking behavior, immigrant, public health, health literacy

ABSTRAKT

Bakgrund: Hälsan i sig och möjligheten att söka vård vid nedsatt hälsa ingår i samhällets folkhälsoansvar. Det ansvaret omfattar även de migranter som finns i Sverige. Hur ohälsa tas omhand inom sjukvården och hur hälsoutvecklingen kan stödjas bland migranter har betydelse för hela samhället och samhällsekonomin.
Syfte: Att ta reda på mönstret för migranter när det gäller att söka vård, vad man söker för, vilka hinder som kan finnas för vårdsökande, både bland migranterna själva och i vårdapparaten och hur dessa problem kan överbryggas.
Metod: Detta är en litteraturbaserad studie. De metoder och den design som användes för att analysera och granska studierna baseras på STROBE och Malteruds granskningsmal för litteraturer studier samt GRADE för metodstyrkan.
Resultat: I den systematiska sökning identifierades 15 artiklar som uppfyllde sökkriterierna. Dessa användes för att svara på frågorna om vårdsökandet och utgjorde underlag för värderingen av den vetenskapliga styrkan när det gäller fynden relaterade till vårdsökandet. Orsaker till vårdsökande omfattade både infektionssjukdomar och icke smittsamma sjukdomar, bland dessa psykisk ohälsa. Det vårdsökande beteendet är bland annat knutet till kulturella uppfattningen om sjukdomars orsaker men också till språkproblem. Sjukvårdens organisation och personalens attityder utgör också hinder för ett adekvat vårdsökande bland migranter.
Slutsats: Vårdsökande beteende hos immigranter i Sverige varierar beroende på bakgrund och etnicitet gällande olika sjukdomar och religiös tro. De mönster som påverkar vårdsökande beteendet är dock desamma hos alla grupper och styrs av kulturella och socioekonomiska faktorer liksom av litteracitet och språkbarriärer.

FOREWORD

I wish to thank my supervisor Ingvar Karlberg for his undefined and unlimited support throughout the consultation period.

To the one person that means the world to my life - VERA SHAZMA
for literally kicking my butt in every unspoken way for me to strive for the best of me.

To the rest of my family and friends who saw the potential in me, encouraged me to pursue my dreams and thought or still think I am the reason they are strong enough to face the challenges of being an immigrant.

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1. INTRODUCTION

In this part of the thesis, I will in the background mention about migration trends generally, describe immigrant health in Sweden, the concern of health inequality and an understanding of healthcare seeking behaviour among immigrants in Sweden as the focus.

Background

1.1 Immigrant health in Sweden

According to immigration trends, the international migrant rate escalated to a total of two hundred and forty-four million in 2015 from two million and thirty-two in 2013 (1). Migrations to Sweden have not been an exception as it constitutes approximately 19 percent of the immigrant population as per a migration and public health report in Sweden, published in 2012. The migrant being defined as one who settles in a country not originally born in (2). Studies done on immigrant health have confirmed that immigrants' health deteriorates due to the effects of migration. This is mostly referred to as 'the migrant effect'. General public health records of immigrants also reveal that the group's ill-health is not only attributed to migration but also their background, as they vary in terms of diseases ranging from infectious to allergic i.e. Tuberculosis, diabetes and cardiovascular diseases to mention but a few. The pathways to immigrant health involve experiences through which the immigrant makes it or does not make it in the new country. In Sweden, the immigrant setting is built up of a combination of challenges revolving social economic, behavioural cultural, communication barriers that affect immigrant health and their access to health services. Immigrants in this context being a vulnerable group of people not natives of the country of settlement (3).
A report from the International Organization for migration confirms that migration can be a determinant of health as it constitutes many factors especially taking into perspective the social determinants of health which are characterised by among others the environment in which one is born, nurtured, grown, gets a job and decides to live until they get old and die. The individual behaviour factor also contributes to the patterns of health among immigrants that either leads to healthy or unhealthy Life (4).

1.2 Health inequality and inequity in Sweden

Sweden's public health goal targets creating viable social conditions for good health on equal terms for the whole population (5). This is a controversial statement which blinds for immigrants without proper documentation and immigrants in general as the extent to which the conditions and services are actually delivered are debatable. According to epidemiological statistics, immigrants have poorer health compared to the natives. (3) This is evident in a study carried out to determine access to health for ethnic minorities in Sweden that points out that immigrants are more susceptible to poorer health due to long term sicknesses, mental illness and poor conditions in the host country. Moreover, the need or demand for healthcare is higher than the actual health services provided for immigrants as compared to Swedes. The source and choice of treatment might be influenced by a number of factors, some of which may include the type of disease affecting an immigrant, the severity of the disease and the immigrants' level of education. The level of education could be used to predict healthcare seeking behaviour (6).
In its varying forms, ill health is perceived to have a fundamental impact on the social, cultural and economic situation of Swedish immigrants. It could have a direct economic impact on a household by reducing productivity, increasing the rate of sick leave, increasing the risk of being laid off and thereby contributing to a decline in household income and

wellbeing. Early diagnosis and proper treatment are key to prevent and reduce morbidity. At the community level, ill-health might force the immigrants to spend less time on the job, which could cause low productivity, which in turn could lead to reduced Gross Domestic Product for a country. Good health is therefore fundamental to the social and economic development (2, 6).

1.3 Understanding Immigrant healthcare seeking behaviour

Healthcare seeking behaviour can be used as an indicator of a patient's willingness to preserve life and it can be perceived as a sequence of remedial actions that individuals receive to treat a perceived ill health. It begins with identifying symptoms, followed by devising a long-term or short-term strategy for treatment. Illness or deviation from a state of health is usually a subjective phenomenon, the relief of which may be sought within or outside of health facilities. Understanding illness has been found to vary with cultural, ethnic and socioeconomic differences. For this reason, healthcare seeking behaviour could be influenced by cultural beliefs about the cause and cure of illness. This could be particularly true for immigrants in Sweden. For effective disease management, immigrants' health-seeking behaviour needs to be understood, as it might influence the duration of symptoms and the probability of morbidity and mortality (7).

Understanding immigrant healthcare seeking behaviour is fundamental in changing behaviour and improving health praxis. Experts in health interventions and policy have become increasingly aware of the influence of human behavioural factors in quality health care provision and uptake. In order to respond to community perspectives and needs on diseases of public health importance, health systems need to adapt their strategies, taking into account the findings from behavioural studies. Healthcare seeking behavioural patterns can be influenced through a combination of learning experiences, which promote awareness, motivation and help to create skills. Also, it is essential to create an environment, which makes positive health practices an easier and more preferred choice (2, 6, 7).

Understanding healthcare seeking behaviour of immigrants in Sweden could therefore help to design and implement interventions that seek to promote early diagnosis, treatment, help educate the immigrants on the importance of disease prevention, correct management and a healthy lifestyle
In order to understand healthcare seeking behaviours of immigrants in Sweden, and to help promote a healthy life style among immigrants, it is crucial to explore healthcare seeking behaviours among immigrants in Sweden and to identify factors hindering their healthcare seeking so as to device interventions to combat the obstacles that will not only prevent disease but also promote health and better the country's economy through an increased workforce (2, 3, 7).

2. OBJECTIVES OF THE STUDY

In this part of the paper, the objectives of the study and the study questions will be outlined to give the reader a better view of what to expect at the end of the research.

2.1 Main objective

To explore healthcare seeking behaviour among immigrants in Sweden and to identify obstacles to healthcare seeking and the possible support that can be given to improve the healthcare seeking behaviours and health outcomes.

2.2 Specific objectives

Study questions that will answer the objective of the study will be;

1. What are the reasons for healthcare seeking and which are the diseases involved during healthcare seeking?
2. What are the obstacles involved with healthcare seeking?
3. What support can be given to improve healthcare seeking?

3. METHODOLOGY

The methodology will entail a descriptive and illustrative reflection of the methods used to retrieve the articles that were reviewed to derive to answers to the objective of the study. (Literature review)

3.1 Study design

This is a systematic literature review paper that will entirely depend on studies previously done in Sweden pertaining healthcare seeking behaviours among immigrants.

A literature based study was chosen so as to review past literature as a basis for future empirical studies on healthcare seeking behaviours among immigrants in Sweden and to highlight the issues that could be tackled regarding the topic. The techniques involved in the literature could be further used for contextually analysing impacts on healthcare seeking behaviours and their outcomes. Articles chosen included both qualitative and quantitative methods.

3.2 Searching criteria

PICO was used to identify the **P**opulation which was Immigrants or migrants, the later due to limited results when the previous was used, **I**ntervention which was healthcare seeking; **C**omparison was blank although in many articles there was comparison to the Swedish population, and the **O**utcome was better health or no better health.
Search words included synonyms such as health literacy or attitudes towards healthcare seeking.

The main databases used were Scopus, PubMed and Cinahl which are known for their diverse supply of scientific material therefore it was important to use them.

First up was to use the title in full to hopefully find relevant articles.

'Healthcare seeking behaviour among immigrants in Sweden' search words had to be changed to 'Healthcare seeking behaviour among Swedish immigrants'
OR 'Healthcare seeking attitudes among immigrants in Sweden'
OR 'Healthcare seeking attitudes among Swedish immigrants'

To get a broader outcome, words such as migrants and heath literacy were used. This was to enable a capture of a broader population but sticking to Sweden as a geographical area.

Abstracts were also read through to match the relevance of the content to the objective of the study and answers to the study questions could be extracted from weighing the article through the abstract. This was helpful in getting relevant studies despite the title not being directly connected to healthcare seeking or immigrants per say. There was for example titles like 'Is there equity in access to health services for ethnic minorities in Sweden.'

3.3 Choice of articles

The articles chosen were all in English and sought from different databases including Scopus, PubMed and Cinahl. The total number of articles found and chosen are presented in table 1.

Manual searches were done as well, from google scholar and super search on the journal of immigrant and minority health.
This was because of the limitation of the search to only Sweden as there were few articles that were specific to healthcare seeking behaviours among immigrants in Sweden on the major databases. The manual search gave a variety of studies which were later used to find more articles from the references.

There were 15 articles altogether of which thirteen used qualitative and two quantitative methods respectively.

3.4 Inclusion and exclusion

As the objective of the study was to identify healthcare seeking behaviours among immigrants in Sweden, search was limited to only the geographical area of Sweden and excluded other countries such as Italy, Denmark, Norway, Canada and USA that popped up a lot, as well as those articles whose abstract seemed relevant for the study however needed purchasing so as to be accessed.

Exclusion of articles were done at a later stage on those that focused only on migrants for shorter economic or work contracts as Immigrants and migrants are two different groups of people and my focus was immigrants due to their intended and or permanent status of stay in Sweden which according to the Swedish migration is at least 12 months. However migrant heads topics or abstracts with migrants were included as the content was relevant for my study.

Inclusion involved all studies done from 1980 to 2018. This was to follow up the development trends of healthcare seeking behaviours among immigrants from the 80's up to date.
Also targeting 2010 and onwards due the immigration influx in Sweden. The articles chosen highlighted the healthcare seeking behaviours of immigrants in Sweden i.e. how they perceived healthcare seeking, what diseases they sought healthcare for, the obstacles faced and what help they could be given to counter the challenges.

Below is a table illustrating how, when and what articles were chosen, and why others were excluded.

Table 1:The table below reflects article search on the different databases.

Date of search	Database	Search words	No. of articles found	No. of chosen articles	Reasons for inclusion	Reasons for exclusion
17th April 2018	PubMed	Healthcare seeking behaviours among immigrants in Sweden	14	1	Relevant to the study questions	Irrelevant to study
17th April 2018	Scopus	Healthcare AND seeking AND behaviour OR attitude OR literacy OR among OR immigrants AND Sweden	391	7- 2	Five chosen / relevant to study	Subtracted two to use in Background
10th April 2018	Cinahl	Healthcare AND seeking behaviours AND Sweden	10	3- 1	Two included for relevance	Subtracted one to use in the background
12th April 2018	Google scholar	Healthcare seeking behaviours among immigrants in Sweden	441,000	5	Titles were relevant to study	Most Articles focused on child asylum seekers
23rd April 2018	*Supersök*	Healthcare seeking behaviours among immigrants in Sweden	13,441	2	Relevant to study	Irrelevant to study

3.5 Quality assessment

Quality assessment will be done using guidelines in the qualitative research series by STROBE (8) and Malterud, who believes our knowledge of medicine is improved through a contemplative and systematic process of textual material in research.
Malterud's guidelines for qualitative studies will by additionally used as most of the chosen articles have qualitative methods. According to Malterud both qualitative and quantitative studies have strategies that should be used as complementary compatibles of each other. However, when processing qualitative studies, one has to consider the triangulation measures for validity as well as relevance and reflexivity (9).

3.6 Data Analysis

3.6.1 Content analysis of obstacles to healthcare seeking behaviour

The method for analysing the content of the articles will be done through text and content analysis method.
In this procedure, data or content analysis involves creation of thematic groups with keen

focus on how many times relevant data appears in the articles chosen. Systematic forms of analysing content may involve the following;

Identifying the relevant data in the articles. (Relevance), Coding and tallying evidence easily recognised from the data. (Code), Formulating themes to represent the data identified (sub-themes), Using themes to address the problem question of the challenges related to healthcare seeking among immigrants (Themes) (10).

Table 2: An example of content analysis of articles on obstacles to healthcare seeking.

Meaning unit	Condensed meaning unit	**Code**	**Subtheme**	**Theme**
They use distant communication technology that affects access to available care (19).	Participants found it difficult to understand and be understood by Providers	Communication difficulty deterring healthcare seeking	Misunderstanding and miss-interpretation leading to distrust	**Language Barrier**
For as long as the person is not causing harm, the sickness is kept a secret within the family. Koran has the powers to heal (21).	Informants believe that mental illness is related to religious impurity and shame	Reading Koran than seeking mental healthcare	Religious beliefs affecting healthcare seeking behaviour	**Religion Influence**
They can be quite racist, not just to the ones from the African continent but it's to every form of immigrants. They don't like things that are different (15)	Providers' attitude towards the immigrant patients was a problem that hindered proper service when immigrants sought care	Difficult to administer care to immigrants due to misconceptions about immigrants	Discrimination causing fear of seeking healthcare	**Providers' Attitude**
It is our responsibility to have better knowledge of different cultures in order to improve their chances to receiving equal treatment *(22)*	Informants found it a challenge to depart from their culture and adapt to the Swedish culture in terms of seeking healthcare	Difficulty in adapting to Swedish behaviour There was unequal job and housing opportunities	Poor housing and health outcomes Poor or low social interaction, economic support and health inequity.	**Social, cultural economic obstacles**
They use distant communication technology that affects access to available care *Sometimes somethings are more important than medication (19)*	The participants had no knowledge on health services available as the information system is too advanced for some immigrants	Lack of proper information regarding services provided in relation to informant illnesses regarding where and whom to contact.	Health illiteracy hindering the understanding of the health system Lack of finance, health inequity, delays in waiting time and medicine expenses	**Health system effects**

3.7 Grade

Grade is the last and most vital part of assessment of the strength of methods used in the scientific studies to be certain of that the study results are based on scientific evidence. The strength of the method used is influenced by factors among others, transferability, data precision, study quality and publication bias or risk of it. RCT studies normally score highly in the grading system while observational studies scoreless or no point at all, also depending on the risk for above mentioned factors. Grade is helpful in preventing risk for wrong interpretation. The three scales grading for the articles assessed are given in the table below (11).

Table 3: Grading method strength

Articles	Method	Evidence strength
14,16,18,23, 24,25,26,27,	Randomised	***
15, 21, 20	Observational	*
13,17,19, 22	Unprecise	

3.8 Ethics

Ethics is an important aspect of a study, therefore important to take all the necessary ethical precautions before research is done, during and after as well as in regard to publication. All articles here in have taken ethical considerations in their studies and well as approval from the respective authorities for scientific and or clinical research (12).

4.RESULTS

The results section shows a review of the articles' quality and assessment of data as well as special findings from the articles on healthcare seeking behaviour, obstacles to healthcare seeking behaviour and what support could be availed.

4.1 Article summary and quality assessment

This is a literature review study with a total of 15 articles from (13) that were searched and found to meet the inclusion criteria and answer the research questions for this study. The articles and results that follow here in reflect methods used in coming up with the healthcare seeking behaviours of immigrants in Sweden and the obstacles facing immigrants in their quest for better health. Also, a few supportive suggestions have been noted. Some methods have been assessed to have high quality in their design for attainment of results.

All studies reviewed were conducted in Sweden focusing on immigrants living in Sweden from different countries of origin. These were observational studies, majority using cross-sectional study design and some were longitudinal. Data were collected using quantitative methods in two studies (14) and (25) mixed methods in one study and remaining studies twelve used qualitative methods. Some studies focused on only immigrants (13, 14 15, 18, 20, 21), while others compared immigrants and natives (15, 19, 23 24, 25, 26, 27). And two studies evaluated healthcare providers of different backgrounds (15, 22). The sample size ranged from four participants (20) to 17,004 (23)

Table 4: Article summary and quality assessment

First Author	Title	Year Published/ setting	Design	Objective	Selection	Study group	Ethical Considerations	Quality of study
Eva Åkeman (13)	Healthcare seeking behaviour in relation to sexual and reproductive health among Thai- born women in Sweden	2017/ Stockholm, Sweden.	Qualitative Study with in-depth interviews for a more personal view on the topic.	To explore Thai women's healthcare seeking behaviour as regards sexual reproductive health and their views on HIV prevention.	Thai women between 18 to 50 yrs. having lived in Stockholm area and in Sweden for not more than five years were contacted through classroom and workplace visits and via mail.	A total of 18 Thai women mostly from language school to capture the newly arrived and with different background of education and social relationships	Informed consent by the participants and Ethics approval for the study obtained from Regional ethical review board, Uppsala.	MEDIUM Randomised selection but small sample size
Faustine KK Nkulu (14)	Screening migrants for tuberculosis- a missed opportunity for improving knowledge and attitudes in high risk groups	2010/ Umeå, Sweden.	Quantitative survey based study with questionnaires based on knowledge and attitudes. Face to face interviews conducted in	To assess the attitudes and knowledge of immigrant student on the screening process for tuberculosis.	Over 16 yrs. Immigrant students in Umeå, registered at the school during the period of study i.e. Oct. 2007-sept. 2008	268 newly arrived immigrants, registered as full time students and could speak a language understood by at least more than two other students.	Doctorate education board of Umeå university approved the study and participants were well informed of the confidential and anonymous nature of the study and parents to minors gave	HIGH Because of large sample size and diverse selection

			different languages for those that were incapable of filling in questionnaires				consent to participation	
Nkulu Kalengayi (15)	"It is a challenge to do it the right way": an interpretive description of caregivers' experiences in caring for migrant patients in Northern Sweden.	2012/ Northern Sweden, unspecified	Qualitative analysis (Interpretive description approach, combining semi-structured interviews with observation)	To explore the perspective and experiences of caregivers in caring for migrant patients in Northern Sweden in order to understand the challenges they face and generate knowledge that could inform clinical practice.	Convenient selection	Ten health professionals were purposefully recruited	The regional ethical committee at Umeå University approved the research and the study was conducted according to the Helsinki declaration.	LOW Observational
Louise Bennet (16)	Self-rated health and social capital in Iraqi immigrants to Sweden: the population-based study	2018/ Malmö, Sweden.	Qualitative Study with health examination and questionnaires answered questions	To study self-rated health in relation to social capital, socioeconomic status, lifestyle and comorbidity in immigrants from Iraq and to compare	Citizens of Malmö born in Iraq and aged 30-75 years were randomly selected from the census register and invited by	A total of 1348 people born in Iraq and 677 people born in Sweden aged 30-65 years participated.	All participants provided written informed consent and the Ethics Committee at Lund University approved the study. This investigation	HIGH Large sample size and Randomised selection

			based on topics pertaining self-rated health, social capital, socioeconomic and lifestyle.	it with the self-rated health of native Swedes.	mail and phone to participate.		conformed to the principles outlined in the Declaration of Helsinki.	
Marco Scarpinati Rosso (17)	Use of cultural formulation in Stockholm. A qualitative study on mental illness experience among migrants	2012 Outpatient clinic in Spånga, Stockholm.	Qualitative study employing a clinical interview process that was divided into three stages including a structured clinical interview for DSM-IV Axis I disorders	To explore the emic perspective of migrants seeking help from a psychiatric outpatient clinic in Stockholm	Selections were made under 2006-2007 of newly referred immigrant patients to the psychiatric outpatient clinic in Spånga	A total of 23 patients were recruited	The study was approved by the Stockholm Regional Research Ethics Committee.	MEDIUM Prospective however small size and use of interpreters alter quality/selection bias

Katarina Hjelm (18)	A qualitative study of developing beliefs about health, illness and healthcare in migrant African women with gestational diabetes living in Sweden	2018/ Sweden, not specified.	Qualitative prospective study with semi-structured interviews conducted on three pregnancy intervals. Interviews were pilot tested before conducted on the study group.	To explore the influence of development over time of beliefs about health illness and health care of pregnant African born women with GDM living in Sweden, on self-care and health seeking	Criteria for selection were over 16year old Women from African countries living in Sweden and dragonised with GDM.	Nine African born women with GDM between 23-40 years living in Sweden and	Consent derived from participants and study carried out appropriately according to Helsinki declaration as well as approval obtained from the ethics committee.	HIGH Because of prospective nature
Katarina Hjelm (19)	Religious and cultural distance in beliefs about health and illness in women with diabetes mellitus of different origin living in Sweden.	2003/ Växjö, Sweden.	Qualitative study where focus group interviews were conducted as a technique in verbalisation to attain different cultural values and beliefs and perspectives	To explore the cultural distance effects on health and illness and self-care behaviours amongst women living in Sweden from different cultural backgrounds diagnosed with DM.	Women of low education diagnosed with DM and having had the disease for more than one year were purposively sampled and correspondents determined by saturation principle in data analysis.	A total of 41 women with DM were included. All with different cultural backgrounds. Arabic, ex-Yugoslavia had lived in Sweden for 10 and five years respectively, and participants from Sweden.	Respondents signed consent of participation and the Ethics committee approved the study.	LOW Because data was collected through focus group discussions. Possible opinion bias.

Arja Lehti (20)	Health, attitude to care and pattern of attendance among gypsy women—a general practice perspective	2001 Umeå, Sweden.	Qualitative study involving in-depth interviews with additional information received from record files.	To explore the reasons for and patterns of attendance among gypsy women in primary health care and to shed light on health problem of gypsies.	Convenient selection targeting the women who attended a health care centre	Four gypsy women, frequently attending a primary health care centre, were interviewed in depth.	All women were informed about the study and it was initially stressed that participation was voluntary.	LOW Because of the group size small
Sara Johnsdotter (21)	Koran reading and negotiation with jinn: strategies to deal with mental ill health among Swedish Somalis	2011/ Malmö, Sweden.	Qualitative interviews and one focus group.	To illustrate the variation of culturally specific ways to apprehend mental ill health with examples from a study about perceptions of mental ill health among Swedish Somalis.	Informants were recruited using snowballing and contact persons for Somalis on different platforms. And random selections made through email and telephones	There were six men, 17 women interviewed. Their ages ranged from 24 to 62 years with a majority being aged between 40 and 55.	Before the interviews, the interviewer explained the study and everyone was explicitly informed of their right to refrain from answering questions they did not feel comfortable with and to terminate the interview at any time without further explanation.	LOW Because of focus groups. Possible domination of opinion by one individual
Sharareh Akhavan (22)	Midwives' views on factors that contribute to health care	2012/ Two municipalities in	Qualitative study involving semi-	To explore the views of midwives on factors that contribute to health		Ten midwives who were professionally trained and had worked in	Participants remained anonymous, and the study was approved by the	LOW Because of selection of only

	inequalities among immigrants in Sweden: a qualitative study	western Sweden (not specified)	structured interviews.	care inequality among immigrants.		the selected district for at least 12 months were selected. Ages ranging 35-57	Ethical Committee in Gothenburg.	Swedish midwives
Gudjon Magnusson (23)	Illness behaviour and nationality	1980 Stockholm, Sweden.	Cross-sectional study by abstracting data from medical records	Part of a larger study aimed at finding out why so many more people use the emergency department at the Huddinge Hospital compared to similar departments at other hospitals in Stockholm.	Selection included everyone meeting the inclusion criteria	17,004 people including those born on the 5th, 15th and 5th day of the month.	17,004 people including those born on the 5th, 15th and 5th day of the month.	HIGH Large group of randomised selection
Eivor Wiking (24)	A description of some aspects of the triangular meeting between immigrant patients, their interpreters and GPs in primary health care in Stockholm, Sweden	2009/ 12 primary health centers in Stockholm, Sweden.	Qualitative design using questionnaires	To describe some aspects of each of the three perspective in the triangular meeting between immigrant patients, interpreters and GPs, including their reflections about these experiences	Convenient selection by consecutively recruiting participants	182 respondents from 12 health centres	Approval from the Research Ethics Committee at the Karolinska Institute	HIGH Large group of participants
Johan Faskunger(25)	Risk of obesity in immigrants compared with	2009/	Quantitative analysis. Random	To estimate the prevalence of, and analyse the	An eligible sample of 678 was pursued to	A sample of 289 individuals	Written formal consent was obtained from all	HIGH

	Swedes in two deprived neighbourhoods	Two deprived neighbourhoods in the South of Stockholm, Sweden	sampling from data obtained through a survey	sociodemographic factors associated with three indices of obesity in different ethnic groups settled in two deprived neighbourhoods in Sweden.	participate in the study from a simple random samples of residents aged 18-65 from two deprived neighbourhoods south of Stockholm through the local government.	who responded to the invitation were then categorized as being Swedish, Other European, and Middle Eastern.	participants/sample.	Random selection and large sample size
Azar Hedemalm (26)	Symptom recognition and health care seeking among immigrants and native Swedish patients with heart failure	2008/ A major university hospital in a multi-ethnic area in western Sweden.	Qualitative design involving semi-structured interviews.	To explore and compare symptom recognition and health care seeking patterns among immigrants and native Swedes with HF.	Random selection as well as consecutively selected sample	42 patients with HF, of whom 21 were consecutively selected immigrants and 21 were randomly selected Swedish patients.	Approval obtained from the Regional Ethical Review Board, Goteborg University. Participants gave their written informed consent to participate before the inclusion and they were assured confidentiality.	HIGH Because of the random selection and prospective nature of study design
Elisabeth Mangrio (27)	Immigrant parents experience with the Swedish child healthcare system	2017 /Southern Sweden. (Not specified)	Qualitative study with semi structured interview questions.	To highlight the non-European immigrant experience of the Swedish healthcare system	Purposive selectin	19 parents 21-45yrs. to under-fives who stayed 22yrs in Sweden.	Conducted in the alignment with the Swedish ethic regulations	HIGH Retrospective With along follow up period

4.2 Reasons for seeking healthcare

4.2.1Epidemiologcal reasons

Immigrants accessed healthcare for screening purposes (14, 13) sexual and reproductive services (13), acute ailments with symptoms such as coughs, fever, stomach upsets (20, 13), non-communicable diseases (18,19), mental health (20, 17 18, 21, 25, 26).

4.2.2 HIV and Tuberculosis

Some immigrants associate their living in Sweden with reduced risk of being infected with HIV and Tuberculosis (14, 13). The knowledge of where to access information on healthcare services was limited among immigrants. When referring to HIV, a study evaluating Thai women found that majority were not aware of where to go for HIV testing and most were not sure which samples had been taken from them during their pregnancy (13). Similar findings were seen when evaluating knowledge on TB whereby it was found that while 85 participants (32%) would turn to healthcare services and (1%) somewhere else. The remaining 67% did not know where to get information about TB (14). It was also reported that some respondents in a study expressed an undue fear of seeking medical attention for fear of being deported because of TB, although the majority did not experience such fears (14).

There was general openness towards getting HIV-tested in Sweden among the respondents with little stigma attached to the disease and testing however positive on the preventative aspects. As most believed that with current advances in the medical field, one could continue living even after contracting the disease. In general, they welcomed information from healthcare providers on the matter (13). A contrast was observed with regard to TB whereby (60%) respondents stated they would rather disclose their illness only to family members than (48%) friends, the remainder would be embarrassed to do so (14). Generally, a very negative attitude towards TB was shown in respondents and diseased persons (14).

4.2.3 Non-communicable diseases and their associated risks (Obesity, Diabetes and Heart Failure)

Non-communicable diseases like diabetes and heart failure (26, 18), and risks of developing them were found to be prevalent among immigrants (25). It was also reported that while obesity was generally prevalent, it was found to be highest among Middle Eastern women (25). Factors associated with risks for non-communicable diseases were reported to include economic difficulties (25). A diagnosis for non-communicable diseases was made coincidentally (25, 18) but in a majority of cases it was after the patient developed symptoms (26). Despite the lack of improvement in the symptoms, at times, the push to seek for care came from family and healthcare professionals (26, 18). There was varying understanding of the importance of responding to medications and management provided (18). The duration of care and follow-up led to minimum changes of immigrants' understanding and attitude towards their intentions to seek care. (26).

4.2.4 Mental Illness

Immigrants were found to have mental illnesses (21, 17).
Perception of mental illnesses among immigrants included that it was caused by being possessed by a variation of evil spirits varying in intensity of their effect on the one being affected (21) but also from one's negative experience from the past (17).
This negative experience included migration, other events or chains of events in the distant and recent past, and being diagnosed with other diseases like cancer (17).
Seeking healthcare for mental illness was a last resort when other traditional and religious means had failed to curb the situation (21). Many of the informants in this same study agreed that as long as a person is not suicidal or attacks others, his condition is reserved within the family in avoidance of stigma and probable social discrimination (21).

4.2.5 Reasons for seeking healthcare while not in illness

Immigrant women who had given birth in Sweden had an idea that they had been in contact with maternal healthcare (13). Another study reported on using the healthcare system to access vaccination services (27). They also sought healthcare services after being invited to participate in a cervical cancer screening programme (13).

4.3 Obstacles for healthcare services seeking

Studies reviewed explored obstacles faced by immigrants when seeking care in Sweden. These factors were mostly cultural including differences in perceived cause of disease (21), language barrier (13), a need to be accompanied (13) and economic status were among the obstacles (25). Healthcare providers (20, 22) and the organization of the healthcare systems were also reported to be external obstacles involved (25, 15, 17).

4.3.1 Culture and religion

Culture and religion played a role in one's perception diseases and influenced one's healthcare seeking. The perception of GDM (Gestational diabetes) was also influenced by religious background whereby supernatural factors were believed to influence one's fate (18). Considering mental health to be in continuum, immigrants in one study did not consider it necessary to seek for medical attention for their perceived milder forms of mental illnesses (21). The cultural beliefs dictated when one would seek for care. One study suggests that formal care, whether hospital in the home country (Somalia) or psychiatric clinics in western countries, was the last resort, and that the most important strategy to deal with mental health seemed to be the mobilisation of social networks (21).

How one sought care was also highly influenced by cultural background and acted as an obstacle. It appears that some women refrain from or delay seeking care while waiting for their partner's assistance. The assistance varies from consulting with them regarding seeking healthcare services, assistance with booking appointments to being

accompanied to the clinic and sometimes serving as interpreter during the visit (13). The same study indicates that this dependency extends to other relatives such as mothers-in-laws, sisters, or other friends of the same background (13). This tendency was also indicated in another study following four gypsy women who, similarly, seldom attended the health centre alone and mostly attended accompanied by one or more relatives or friends (20).

Another study reported that because of religious and cultural background, immigrants would prefer to be attended by a provider of a particular sex than another (15). The management of diseases was also highly influenced by religious and cultural background. In a study involving Swedish Somalis (21), it appeared that reading the Koran was a key strategy to deal with mental illness which members of the community who are also Muslim believe to have healing powers (21). Further, a belief in *jinn*—used to express that someone is possessed by a *jinni*, an evil spirit—which all Muslims believe in, impacts healthcare seeking behaviour as this is something they believe to be cured/improved through reading the Koran (21).

4.3.2 Language barrier, interpretation and challenges thereof

Because of insufficient understanding of the Swedish language, some immigrant women chose to undergo or planned for a health examination while visiting their home country (Thailand) on preventative grounds (13). In another case, a woman sought a second opinion in Thailand because she was unsure whether she had understood the Swedish doctor's advice (13). Immigrants were also reported to miss their appointment due to language barriers and had to pay the none-attendance fines (15). Language barrier also led to limited understanding of one's rights and consequently not being able to request for patient's rights related to healthcare (22).

While being able to communicate well with a patient albeit through the use of an interpreter is necessary in order to provide the best care, participants in one study suggest that not using professionally trained medical interpreters can be of less help in assisting the care giver and the patient to understand each other (22). A study indicated that a lack of knowledge about the Swedish healthcare system coupled with insufficient knowledge of the Swedish language complicated communication with medical staff and caused some immigrant women to refrain from seeking care within Sweden (13). In the matter of milder mental ill health, the reluctance to turn to western professionals is also a matter of clash of reference of frames (21). According to this study, it appears that Somali immigrants in western societies doubt that there is much help to get from seeing western psychologists of psychiatrists not only because of their limited knowledge on the psychological strain of this community resulting from the experiences of war in their native land or by their relatives still there, but also because of the management of some mental ill health by a lifetime of medication (21). Although many positives were mentioned regarding the use of interpreters and especially those formally trained with medical knowledge, there have been cases of interpreters misleading patients by for example speaking about the wrong disease just because they did not know what the right word in that immigrant's language was (14).

4.3.3 Economy

Immigrants from the Middle East reported about two times higher percentages of economic difficulties than Swedes (25). It seemed to take a long time to see a doctor, and time that an immigrant would prefer to use in making an income. In a study where the family's economy was a hinder for seeking healthcare was based on the lack of finance to buy the medicines that would be prescribed. That one would prefer to use the money on other expenses than buy medicines. 'Sometimes somethings are more important than medication.' (19).

4.3.4 Social capital

A study involving Iraqi immigrants reports that Iraqi men and women were poorer in all aspects of social capital, with higher proportions experiencing low social participation and anchorage, as well as low emotional and instrumental support (16). The study further reports that Iraqi men were worse off in all these aspects with 80% of Iraqi men reporting low social participation (16). The Iraqi population also experienced socioeconomic vulnerability to a higher extent, with a higher percentage being unemployed, having economic difficulties and reporting low level of education (16). In addition, Iraqi-born participants were less physically active and had one or several chronic diseases such as depression, obesity and type two diabetes of a higher degree (16).

4.3.5 Wanting immediate relief

It was observed that immigrants from rural areas in Asia were less willing to submit for too long to treatment and follow-up for chronic diseases. It seems they expect immediate relief and may discontinue the contact when such treatment is not received (23).
The participants in another study suggested that through the reading of Koran and medication in their native land, people were healed of mental illnesses such as schizophrenia and were not confined to a lifetime of medication offered in Sweden which causes a change of appearance in the patient for example walking differently, gaining weight among others which in a way announces to others of the problems this individual is experiencing (21).

4.3.6 Obstacles related to the health system

There are other barriers to seeking healthcare other than incompetence regarding the Swedish society and rules (17). Participants in this study found the Swedish health system to be ineffective, unfriendly, and very difficult to cope with (17) and most chose to turn to their homelands for healthcare (13).

4.3.7 Health workers' attitude towards immigrants

Some healthcare workers seem to be bothered by the immigrants' dependency on their partners, and others by the difficulty of providing care to an immigrant with the use of an interpreter (20). Another study, however, indicates that providing care to immigrants who need the assistance of an interpreter lengthens the time they spend with the patient

while health care providers are required to maintain a set time for each patient which cannot be extended (22).
Some immigrants expressed feelings of being marginalized which for some meant losing contact with every meaningful person in their life. However, none of the respondents expressed occurrences of active discrimination or racism (17).

4.3.8 Waiting time (Doctor Appointments)

Lack of information about the organization of healthcare together with language problems also contributes to the fact that immigrants use hospital outpatient clinics significantly less than Swedes (13, 23). The same study states that outpatient clinics must be booked in advance and that there usually is a delay of some months for any new visit (23). A referral letter is the major way through which a majority comes to the outpatient clinics. The study suggested that immigrants possibly use outpatient clinics less often could indicate that they less often use health services outside the hospital such as health centres, private physicians and occupational health services—services which usually act as entry points to the outpatient clinic through referral letters. Various possible explanations for this scenario were given as being social, cultural and psychological (23).

4.3.9 Trust and confidence

Some immigrant women distrust health care systems because of certain policies. One study indicates that the Swedish health care guidelines call for X-raying pregnant women from certain countries because of the risk of tuberculosis (22). Pregnant women in general are not X-rayed but in the case of immigrant women an exception is made, but some immigrant women refuse to be X-rayed while pregnant and this in turn causes mistrust to a system that has such a policy (22). The same study indicated that sometimes women do not disclose full information for fear of immigration authorities and it can be limiting to the health care they and their families receive. This is the case for example with Somalian women who are raising children who are not biologically their own, but due to fear of that information reaching immigration authorities, they choose not to disclose to the midwife information such as how many children they have given birth to (22).

4.4 Support

4.4.1 Improving the healthcare seeking behaviour among immigrants

a. From the perspective of the individual
    i. Getting translation assistance
    ii. Somehow incorporating cultural aspects/procedures into Western practices of healing. Participants in one study showed that treatment offered at a collective level within a community and also religious ritual have a real impact on health and well-being; as a result, there is reason to assume that such procedures (as described by Swedish Somalis in that study) can make an actual difference in people's lives (21).

iii. Health care workers should strive to learn about cultural diversity so that they can improve the immigrants' chances of receiving equal treatment (22).

b. From the government perspective
   i. Provide as much information as possible. Because immigrants may not know what exactly they can get help with or which services are available to them, it may limit their utilization of such services. It is up to society to provide this information so that they know their rights and the knowledge of what is accessible to them (22). This can also include a better introduction for when immigrants come into the country of what facilities are available to them.
   ii. Ensure that health care workers' training includes cultural diversity and cultural sensitivity (22).

5. DISCUSSION

This part entails the issues raised in the results part and also pointing out any new findings. The methodology discussion involves the cons and pros of the methods used in the articles to attainment of their quality and grade of method strength.

5.1 Methodology discussion

This research paper is a literature based study. The method choice was vital so as to explore the healthcare seeking behaviour of immigrants in Sweden from available literature on the topic. The study was based on other literature studies done in Sweden from 1980 (23) to 2018 (16, 18).

The intention of searching back in time was to monitor the development trends in healthcare seeking behaviour among immigrants in Sweden which is not peculiar in its findings as there are still challenges faced in healthcare seeking behaviours among immigrants now as it was back in the 80's (23). Despite the fact that migration trends today changed.
Results that emerged from the chosen articles showed no significant difference either, pointing to same or similar results which mean the method was appropriate (13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, (24),25, 26, 27) .
The articles were both qualitative and quantitative studies with different ethnic backgrounds, population and diseases for which healthcare were sought.
This was regarded as strength in that it covers all possible groups for a more reliable outcome and strengthens the quality of some of the studies. Moreover, most of the studies conformed to the various challenges faced during healthcare seeking and the different types of diseases were found in different other ethnic groups as well.

Some studies were chosen despite the minimum number of participants (13, 15, 17, 20, 22). which comes as a weakness when regarding sample size of participants. However, due to limited results from Sweden they had to be included. Other articles have had larger populations (25), varying in terms of age, ethnic group social economic, education status, to length of stay in Sweden and length of having had a disease (14, 16, 19, 21, 23, 24, 25, 26)
It turns out unfortunately that there are not so many studies on this very topic.

Neither the topic nor choice of words gave the expected titles searched through the four major scientific databases therefor I expanded the search criteria and engaged in reading abstracts from the search findings.
That's why the chosen articles have got elements of healthcare seeking, behaviour or attitudes, immigrants, various diseases mentioned and Sweden as geographical area.

All articles were analysed based on the overall quality of the study (STROBE) having a quality of either Low, medium or high as well as the strength of the methods used (GRADE) bearing one, two or three stars. The grading was however done on the overall conformity of the studies to same or similar results achieved.
The different methods and designs used in the studies have been helpful in understanding the actual problems faced by immigrants in Sweden during healthcare seeking, what diseases they seek healthcare for and the public health outcomes. However, above all is realising the vitality of using systematic assessment and analysis that is important in scientific results and interventions that are evidence based.

5.2 Results discussion

5.2.1 Reasons for seeking healthcare

It turns out the method (Literature based study) chosen for this study has given expected results. The choice of topic was made due to concerns about the treatment given to immigrants in Sweden during their encounter with health workers and the propaganda of healthcare seeking behaviour and recognizing signs of illness (26), among this group.
The results attained from the selected studies were varying in terms of ethnic backgrounds but not in the behaviour, although some behaviour may be considered extreme for example patients expecting providers to cure diseases that probably have no cure or that can be tamed by medication. This was affected by the belief towards consuming medicine was generally negative especially noted in the Somali culture.
Healthcare seeking behaviour among immigrants in Sweden according to the studies above reflect both good as well as the need for improvement in all areas from individual efforts to government responsibility in restructuring the healthcare system to a friendlier stadium for healthcare seeking immigrants just like it is for the Swedes.
There were quite special findings in regard to culture and beliefs as regards culture especially in the Somali immigrants where the Koran is expected to heal mental illness as opposed to seeking healthcare from health centres and the risk of taking pills all life (23)
It was also noted that Arabs have poorer healthcare seeking behaviour compared to other immigrant groups which may be associated to their strong belief in Religious rooting (16).

According to the methods and designs that have been used in the articles, STROBE and GRADE have been well applied in determining both the quality and the strength of their methods and designs. (8, 9, 11)
I however believe that there is a risk of misinterpretation when it comes to designs like content analysis.
In literature review, quoting someone's words and referencing to the original person is said to be effective in as far as originality is concerned.
However, this may lead to misinterpretation and thus the meaning or intention of the message may not give the intended value. Moreover, it could go overboard ethics considerations as one may identify themselves in the text despite using other names.

To avoid that sometimes the content analysis criteria has been devised for coding and creating themes which are then used to identify the problem. There is more to this than meets the eye that needs further research.

5.2.2 Obstacles for seeking healthcare and Support

Besides all obstacles named, like language barrier, economic hindrances, health illiteracy, cultural social influences, there is need to acknowledge that some providers do welcome and treat immigrants with respect and care (27), and the free medical consultation services provided in Sweden should be appreciated. This can or should also be seen as an opportunity to more healthcare seeking behaviour among immigrants. However, the challenges probably need to be combated for the smooth running of the healthcare system and for the availability of free services to be effectively used (15, 19, 21, 22)

5.2.3 Gender aspects

Gender plays a great role in public health and the difference in diseases between men and women (28).The gender issues raised in the articles highlight more nurses and providers to be women than men (13, 20, 23).
This could be the reason some patients refuse to speak or cooperate with the nurses because of their expectation to meet male doctors and worst of all with the belief that their sicknesses will automatically be healed.
There were also more articles that mentioned women seeking healthcare as compared to men. I believe it is the culture of women to be more prone to diseases than men but also the fact that women care about the body changes and reactions more as compared to men therefore more healthcare visits mentioned among women (15, 17, 20, 22, 23).

5.2.4 Social Determinants of health and health economics

As mentioned before, healthcare seeking behaviour is affected by many factors including our economy and the affordability of for example medicines and transportation to hospitals etc. Our economy and that of the country is affected by not seeking healthcare or not getting access to healthcare when sought, getting sick and having to take sick leave (2).
Health economics explains the relationship between health and economics where our economy is very dependant of our health. This is evidenced in Karlberg's introduction to health economics book that the greatest threat to Sweden's public health from the eighties and early nineties has been infectious diseases like Tuberculosis despite measures to combat it, that's why the healthcare system's role in public health is of great importance.
The national economy of Sweden therefore can be at stake if responsibility to take public health measures neglected because as human capital in health economic terms, obstacles to good health affect our daily lives as well as our productivity and this in turn affects not only our health but also our economy and that of the country at large (29).

5.3 Interventions.

5.3.1 Healthcare system solutions

My suggestions to healthcare system solutions that I believe will help combat challenges in healthcare seeking behaviour among immigrants in Sweden through structural interventions.

Table 5: Showing suggested Interventions

Recruiting more staff with basic comprehension of cultural diversity	Interpretation services should be availed to solve communication barrier problems	Training healthcare workers to be culturally competent	Health Education action programs that multilingual and cultural	Cultural healthcare settings

- Reflection of diversity by healthcare givers in the society
- There will be fewer communication misunderstandings as the training given to HC providers will have armoured them with awareness of disease and cultural differences
- HC workers attitude will change towards discriminating and neglecting immigrants

- The above will lead to improved care due to understanding and respecting differences regarding care seeking
- Reduce the health inequality gap in Sweden
- Whish will Improve public health of the Sweden population

6. CONCLUSION

The articulation of results in this study mirrors healthcare seeking behavior among immigrants in Sweden as a problem that needs public health interventions from a structural level. There however needs individuals' effort as well which is seen to be influenced by the different ethnic backgrounds in terms of illness and praxis.
It has been evidenced that Immigrants in Sweden seek healthcare as well as refrain from it due to various obstacles ranging from language barrier, low educational level and health illiteracy, cultural and economic, to provider's attitude towards immigrants and the health system set up.
A combination of these has led to an increased health inequality between immigrants and swedes. This is a crucial public health issue that if not attended to could continue to affect the public, healthcare system and general workforce which may also affect the economic growth of the country as many take sick leave.

Conclusively, public health should not only be viewed as the responsibility of the healthcare system or just the individual in regard to choice of lifestyle and behavior, but as a collective responsibility of the general public that needs collaborative interventions.

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