# Report on study visit to Huddinge Karolinska, Fittja MVC and Skärholmens UM, Stockholm

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## Background and introduction

An obstetrician-gynaecologist since 1981, I work as a consultant in Jorvi Hospital, Espoo, Finland, mainly in the obstetric section. I have for long been interested in immigrants, and have several times worked for the International Red Cross in the third world, principally in refugee programs.
My motive for the visit was to learn more about immigrant women. The basic aims were to diminish friction in the hospital when dealing with immigrants, to increase understanding between immigrant patients and personnel, and to see whether and how we need to improve or change some working methods or our predominantly Nordic thinking when our obstetric and gynaecological (OG) patients come from other cultures.

I applied for the NFOG visitor program for two reasons.
The main reason was to learn about problems observed in Sweden when immigrant women search health care in gynaecology and obstetrics.

Cultural background deeply influences body image and perception of health and illness, and is reflected in attitudes, expectations and reactions to health care. Women from different cultures can be expected to have a spectrum of differing responses to their symptoms, the consecutive examinations and their treatments, especially in the area of reproductive health. Misunderstanding, misinterpretation, lack of common language and poor communication with personnel may create complications, cause over- or underdiagnosis and lead to long term harmful effects, not only for the patient but for her family as well.

The second reason was to reinforce Nordic networking in clinical practice.

Congresses and meetings are actively arranged within the Nordic medical field, but international interpersonal contacts hardly develop for others than high ranking and decorated scientific professionals. The ordinary unremarkable practitioner gets the training, but if a miracle doesn´t happen, never manages to form longer lasting ties to the corresponding colleagues nor gets the opportunity to see how ordinary clinic days differ in our neighbouring country institutions. How do my Nordic colleagues deal with the grass root level problems I face frequently in the delivery room? What is “a difficult patient” for them, and how is she dealt with? Is hardship experienced in the same issues? Is the teamwork with midwives as easygoing as in my country? Could I learn something practical for my everyday work?

In western medicine practices still differ in some of the most common procedures. Though thousands of women give birth daily, we have not always been able to have a consensus even for some everyday routines like episiotomy or induction of labor. No wonder then if third world countries have their own protocols.
In a Swedish delivery room, my view is that of a foreigner. Even Sweden manages to offer slight cultural diversity. It is more easy to try to identify with someone coming from far away, now surrounded by strange and perhaps wildly nonreassuring practices.
If Cochrane reviews cannot always show which way things are done best, then perhaps it is not possible or even good to try to have a consensus in practices which have strong elements of culture or tradition. Perhaps what is needed is greater sensitivity and more wisdom. Why not be as flexible as possible, if it helps our patient?

**Planning of the visit**

A week is a very short time. Yet it allows a refreshing dip into the different pool. It allows time to interview a number of health workers. At the same time the visitor feels the atmosphere, gets a glimpse of the attitudes, the clientele, the degree of work load on a given period, the surroundings – the hospital rooms, the equipment, the organization of work, how patients are received, even how colleagues have coffee and arrange their lunch – lots of details are caught involuntarily and serve as a basis for comparison with one´s own work place.

My aim was to focus on immigrant women and their specific characteristics as consumers of our nordic reproductive health services – whether there are any characteristics at all, whether there is some uniformity, and whether problems are handled in Sweden in a way we in Finland could learn about.

Limiting the observation of immigrant women´s OG problems to sheer medical issues is narrow. The view should involve much more - anthropological and sociological and also psychological, religious, political, historical and legislative aspects.

Sweden´s immigrant policy and its changing trends would have been interesting to illustrate by getting hand of some figures and present policy guidelines. To stretch that far was too ambitious.

It is emphasized that only the perspective of the health care givers was evaluated. Patient views were not sought.

Immigrant gynaecology and obstetrics is not a registered trademark. To choose between Uppsala, Gothenburg or Stockholm I got advice from a Swedish public health nurse familiar with refugee work. Another colleague from Finland with good contacts due to her scientific research work gave a referral for who to negotiate with in Karolinska, and I sent an inquiry.

That is how the plan got an address.

Huddinge and surroundings with its high prevalence of immigrants was the target area and Huddinge Sjukhus was to be the coordinating institution.

The planning was done by mail, e-mail and phone.

I received a welcome letter from Karolinska from the head of OG department Dr. Karin Pettersson. The program plan was decided to be made together in advance with a local doctor.

Dr. Katja Lampinen was my counterpart and facilitator. She was very helpful in giving suggestions and telling me what could be found in the surrounding areas. As the program got its form, she discussed with potential contact persons and prepared and organized meetings in advance.

By the time I left for Sweden, we had a meeting schedule ready for the week.

**Program in practice**

The program started on a Monday morning with the clinic meeting, an introduction to the head of section and the head midwife and a visit of the OG clinic in Huddinge, both delivery room and gynaecological policlinic.

In the hospital during the course of the week I interviewed the clinic chief, the head midwife, the social curator and the psychotherapist, among other doctors and midwives. I followed the outpatient activities in the unit of substance abuse with the consultant in charge. I participated in the hospital morning meetings on three days. I gave a lecture in the Wednesday afternoon clinic meeting.

Other days were spent doing interviews in Skärholmens Ungdomsmottagning and for one whole day in Fittja Mödravårdscenter, where I followed the midwife running her outpatient clinic and discussed with the midwives in charge.

The interviews were all done with the health care givers´ perspective as the objective. They were done in Swedish, doubling the study week for an efficient intensive brush up course in Swedish.

I had been asked in advance to give a lecture to the OG doctors of Huddinge on my Red Cross work. This lecture was given in English.

## Results

The expectations and promises were realistic. Nothing very new or quite revolutionary was supposed to be revealed. Yet interviewing several experienced people with time gave valuable general insight in addition to a few quite detailed notions.
Some opinions came through in several interviewees´ answers and remarks and can be presumed to reflect successes or failures of the Swedish immigrant policy. I did not come across contradicting opinions in these ideas.
Some viewpoints highlighted in the interviews are presented below:

- immigrants should not be settled in their own areas
- learning the language is for the immigrant one of the first and most important ways to become integrated
- work should be given immediately to facilitate integration, to train language and to help to understand the Swedish way of life
- family oriented cultures prevail not only in the Near East but likewise in Africa, Asia and even Latin America, and some understanding of their traditional and religious concepts is necessary
- in illness and childbirth, support from the family and from other women in the community are important sources of consolation and relief to immigrant women
- there is a clear ideological rejection of anatomical virginity, considered by many Swedish doctors as a “myth”
- on the other hand, much comprehension was shown to girls from patriarchal cultures, where virginity has an enormous symbolic importance
- wedding ceremony is an important social event in many cultures outside Europe, involving not only the couple but their families as well
- conservatism increases and traditions are reinforced in an unfamiliar environment – immigrant fathers often turn to ultraconservative values in order to preserve status and authority in the family
- immigrant patients often need a double appointment time
- the anatomic knowledge of many immigrant women is poor
- young immigrant men are often very ignorant in health issues
- immigrants may not have any words for their feelings
- many immigrants have already been subjected to violence or lost family members before arrival, which makes them especially vulnerable
- women should be questioned about violence
- immigrants sometimes need that the decision be made quite authoritatively by an outsider (the doctor); “rules must be broken” when the situation demands

- professional interpreter services are in many situations essential, and their quality varies
- some special services are concentrated in Stockholm in corresponding centers where treatment is given by specialized staff: circumcision sequelae, HIV positive women, torture victims, rape victims; several women´s groups or associations exist and take care of particular ethnic groups
- it is of paramount importance that health workers dealing with immigrants are persons who are interested in foreign cultures and enjoy seeing matters in more unconventional ways

**Personal impression of the visit**

In spite of its shortness the visit was useful. I got new bits of knowledge and new insight, and was not disappointed – I had not expected anything unrealistic.

The preliminary schedules worked well, not much adjustment was needed. The atmosphere was friendly and easygoing and the persons interviewed were active and expressed their ideas and experiences fluently. I felt welcome from the start.

I would have appreciated more time with my individual colleagues for ordinary chatting about their thoughts, but the purpose of the visit was not a get-together.

Structurally the hospital resembled a big business center with its streets, not so much a hospital at first sight. There was much free space around with comfortable waiting areas and cafeterias, restaurants, bank and mail services available.

In every hall, waiting room and corridor, I could see women from all parts of the world.

My facilitator had done a great job preparing the meetings, besides she gave me all the practical help needed once I had arrived.

I was pleased to have an interested audience for my lecture and relevant questions from the public.

Swedish midwives seem to have the same good qualities as ours – a lot of initiative, readiness to take much responsibility, and no barriers for working in a good team with obstetricians. An impressing variety of different languages are mastered by the partly multicultural personnel.

My Swedish was activated, and contacts were created.

This visit to Huddinge, Fittja and Skärholmen gave valuable material for my lecture scheduled for Jorvi Hospital OG staff next fall. Huddinge has 4800 deliveries per year and a caesarean rate of around 18%, which allows some comparison with Jorvi Hospital´s 3600 deliveries and 16% caesarean rate.

It also left a feeling that an opportunity to work in Sweden for some time in the future would be very inspiring.

Coming back home, when I saw the first Somali refugee in Helsinki, I at once perceived that I was looking at her with slightly different eyes.

## Conclusions and recommendations

Compared to Finland, Sweden has a much larger volume of experience concerning immigrants and their specific needs. The health system in Sweden is largely similar to the one in Finland, and the Nordic common values and comparable cultural atmosphere should allow many generalisations to be made between Sweden and Finland.

Immigrant women are an interesting subgroup of gynaecologic and obstetric patients. Initial incompatibility with some demands of the Nordic culture is highly probable, and increased friction in between generations can be expected. Traumatic past experiences of violence and loss, or periods of living in constant danger, fear and insecurity, cause a burden which may be reflected when immigrant women search health care. Some immigrants manage better than natives in their health problems, partly by getting traditional support from their own relatives, partly as a result of their more realistic attitudes and natural acceptance of sickness, suffering and death as parts of human life.
Young immigrant women coming from very patriarchal and traditional cultures are especially vulnerable. Adaptation to a much more autonomous role in the new environment may prove too difficult, as it requires adjustment not only from the girl but also a considerable change in the family´s gender attitudes.

The concept of a large extended family and some understanding of its unwritten obligations and limitations for the individual family member are essential for all health workers dealing with immigrants.

Lack of understanding and language problems complicate the communication with the health personnel. Minor health worries can become overwhelming because of ignorance. Psychosocial problematics are common. Close collaboration with social workers is needed. Exotic diseases, substance abuse or prostitution related problems seem to be very minor issues.

Immigrants may get a label of difficult patients. Sometimes they are, and reasons are many. Immigrants often need extra time and special services like professional interpreter help. Training and information to increase our knowledge about their background and way of life diminish prejudices, which we all have. Like indigenous patients, immigrants need

understanding and empathy from health workers, who should be genuinely interested in them and in seeing things from a different perspective. Immigrants are mostly very thankful patients and have high respect for the Nordic health care.

In the future, information on selected details could be collected likewise from the immigrants. This can be accomplished in Finland. The viewpoints the immigrants would highlight may quite well be totally different from those we have presumed.

Visits like this can be encouraged. They give new ideas and always increase understanding between different groups, whatever they be.

*As the share of patients who have come to Finland from foreign cultures is rapidly increasing, the related problems need emphasis. Pregnancy and childbirth are one of the most frequent causes immigrant women seek help for in their new health care system, often right in the beginning. In general it seems that even many freshly arrived immigrant women manage well in our Nordic maternity services, and may even have assets modern Nordic women never dream of. Especially vulnerable are immigrant women without residence permit, those who are alone, those submitted to domestic violence or social seclusion, or women with injuries from traumatic experiences, violence or previous disease.*

*Immigrant policy makers and social authorities should have continuous active feedback from the sensitive health sector, where the negative consequences of unwise political decisions are reflected.*

*It has been since long recognised that in developing countries the single best investment in order to improve the well-being and the health of the whole family is to invest in mothers and their education. It is logical to claim that in order to integrate immigrants to their new country, investing in immigrant mothers is paramount. In this, as OG staff we are in a first hand position.*

I am grateful to Jorvi Hospital, Karolinska and NFOG for giving me the opportunity to this visit.
I want to express my sincere thanks to all the friendly personnel and colleagues who gave me their time, answered my questions and assisted me in collecting my material during the early summer week in beautiful Stockholm.

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