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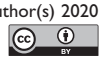

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# Asylum seekers' lived experiences of dignity during health examination: A phenomenological hermeneutical study

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## Abstract

For newly arrived asylum seekers, a health examination is common practice in many countries. For asylum seekers, this part of the asylum-seeking process can be experienced as a burden due to communication barriers, feelings of mistrust and insecurity and the experience of being an object rather than an individual. The aim of this study was to explore asylum seekers' lived experiences of dignity while undergoing a health examination. Eight asylum seekers participated in individual in-depth interviews. A phenomenological hermeneutical approach was used to analyse the collected data. The study is reported in accordance with COREQ guidelines. The lived experience of dignity was linked to dignity violation as well as to dignity safeguarded. The participants experienced anxiety about how they would be received. Some were met with kindness and care, but there were also many incidents of demeaning behaviour. With an interpreter present, the participants experienced that they could not speak freely. Numerous healthcare personnel and frequent transfers caused confusion and insecurity. Well-organised health centres made participants experience a sense of safety and respect. The results can be understood as a pattern consisting of four categories: rights-related, care-related, communication-related and system-related. This small study, which limits the conclusions that can be drawn, conveys that ethical awareness and professional expertise may contribute to safeguarding asylum seekers' dignity in the above categories during a health examination.

## Keywords

asylum seekers, caring, dignity, health examination, nursing

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## Introduction

For newly arrived asylum seekers, a health examination is common practice in many countries. The main purpose of the health examination is to identify health problems and offer adequate care in order to secure and improve the health and well-being of every asylum seeker. In most host countries, the health examination is partly voluntarily and partly compulsory (communicable diseases). According to the Universal Declaration of Human Rights,[1] all asylum seekers have the right to receive health services. The guidelines for the health examination exist to ensure that all asylum seekers receive the services to which they are entitled.[2] For many asylum seekers, the health examination is their first encounter with the healthcare system in the host country.[3] Asylum seekers are in a vulnerable situation due to unpleasant experiences and exposures in their home countries and during migration.[4,5] Previous research[3–5,7,8] reports that the health examination can be a burden for them due to poor communication and information, cultural barriers and misunderstandings, unmet needs and expectations, feelings of ambiguity, mistrust and insecurity and the experience of being more an object than a unique individual. Asylum seekers also reported that their psychological and emotional needs and problems are overlooked during the health examination,[6,9] even though these are known to be significant health problems for asylum seekers.[8,10,11] Many asylum seekers are aware of the necessity to undergo a health examination,[4] but they describe it as being more of a communicable disease control rather than an effort to take care of their health needs.[4,6] Asylum seekers also fear collaboration between the immigration system and the healthcare system.[4,12] All of these experiences of asylum seekers can be classified into individual, provider and system-related barriers, as described by Asgary and Segar.[12] The above studies imply that asylum seekers might face complex challenges in connection with their health examination. But the

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health examination is experienced by some as beneficial, as they receive help for their health problems and feel cared for on a personal level by friendly staff.[8] In a study conducted by Lobo Pacheco et al.,[6] most of the respondents ($n = 386$) reported that they had been treated with respect.

Dignity is a core concept in ethics.[13] The word dignity, which stems from the Latin *dignitas*, means 'being worthy'.[13] Gastman[14] argues that dignity can be reflected in the perspective of human rights and human duties. Gastman[14] further argues that lived experiences must be the starting point when exploring dignity. Dignity as a human right is founded in the Universal Declaration of Human Rights,[1] which states that all human beings are born free and equal in dignity and rights. As a duty, dignity means accepting to serve with love and to exist for the sake of others.[15] According to Eriksson,[16] dignity is the ability to see the other person as he/she is and then assume responsibility for that person. A human being's absolute dignity is characterised by responsibility, freedom, duty and service.[13] Relative dignity is characterised by the bodily, external aesthetic dimension and the psychical, though also with an inner ethical dimension.[17] Experiences of relative dignity are of dignity that is either violated or promoted in a social setting in which interaction between people takes place.[18] Jacobson[19] and Edlund[17] argue that there is a reciprocal relationship between health and dignity. Previous research on asylum seekers' experiences of dignity, and especially the lived experiences of dignity during the health examination, are scarce. Consequently, more knowledge is warranted to support a dignified health examination for asylum seekers. This study therefore aimed to explore asylum seekers' lived experiences of dignity during their health examination.

## Method and design

The study employed a qualitative design in which data were collected by means of in-depth interviews[20] and the transcribed texts were analysed using Lindseth and Norbergs's[21] phenomenological hermeneutical method. This study is reported in accordance with the Tong et al.[22] 'Consolidated Criteria for Reporting Qualitative Research' (COREQ) guidelines.

### Study context

The asylum seekers who participated in this study underwent a health examination within three months of their arrival in Norway. The participants first received an invitation to a health examination written in their native language. The health examination involved a compulsory tuberculosis screening, in addition to a voluntary medical examination with a medical-general practitioner and a health consultation with a public health nurse. Pregnant women underwent a consultation with a midwife. If necessary, the asylum seekers were referred to other primary health services or special health services.

### Recruitment and participants

The participants in this study were asylum seekers who had arrived in Norway between 2014 and 2017, the majority in 2015. There was a large influx of asylum seekers in 2015, which posed a challenge to the different municipalities in terms of access to staff, infrastructure and funding, so additional asylum centres were established in several communities. While waiting for their asylum applications to be processed, the asylum seekers lived at either asylum centres or in community housing. At the time of the interview, the participants were classified as refugees.

The participants were recruited through the community migrant adult education facilities in two municipalities in the same county. The schools were informed in advance about the study. After we received the schools' permission to recruit participants, current participants received verbal and written information from the first author, which explained the background and aim of the study, the right to informed consent and confidentiality, how the data would be used, the researcher's background and interest in the topic. The participants were informed that an interpreter would be required during the entire interview to ensure the quality of communication. Information was written in different languages. Those who wanted to participate were required to sign a consent of participation. Approximately half of the classes wanted to participate. An interview appointment was then scheduled. We chose not to limit participants to a specific nationality or gender, but to limit age for reasons of legality. There were eight participants, two women and six men between the ages of 18 and 60 years. Seven participants had children, varying in age from new-born to primary-school age. One participant did not have a family.

### Data collection

The first author, who speaks Norwegian and English fluently and has clinical experience with asylum seekers and interpreters, carried out one in-depth interview with each participant face to face in a private room at the participant's school. During the interviews, interpreters from an approved interpreting centre were present on the phone to facilitate clarity of communication. The confidentiality of the interview was emphasised to both the participants and interpreters before proceeding to the interview. The participants were excited and nervous during the first few minutes. But they eventually became more relaxed, making the conversations less tense. Using an interview guide, the participants were asked about their expectations of the health examination and how they were taken care of. More importantly, they were asked about what dignity meant to them and how they experienced dignity during the health examination. The participants were encouraged to comment broadly on the topic. Their responses varied from short and concise to highly descriptive answers and explanations. Field notes were taken during and after each interview.[20,21] The interviews lasted for approximately one hour. The interviews were audio-recorded. The first author

transcribed and translated the interviews. The transcripts and translation were then approved by the second author.

### Data analysis

The data were analysed using a phenomenological hermeneutical method developed by Lindseth and Norberg.[21] Interpreting a text using this phenomenological hermeneutical method involves three methodological steps: naïve understanding, structural analysis and comprehensive understanding. Firstly, the text produced after transcribing the interviews verbatim was read several times by both authors to establish the essence of the meaning of the text as a whole. This gave us a naïve understanding and led us to the second step, the structural analysis, which is thematic. Themes were identified in the manner they were described, not formulated as abstract concepts. These themes represented meaning units and were a reflection of the naive understanding. The meaning units were condensed and classified into sub-themes and themes. It is vital to view the text as objectively as possible during the structural analysis. The process involves identifying and separating the text parts from the whole context. It is sometimes possible, however, to find more than one essential meaning from a single meaning unit. During the third step, we reread the text with the naïve understanding and validated themes in mind. This led us to a comprehensive understanding. According to Lindseth and Norberg,[21] we used our pre-understanding to interpret, revise, broaden and deepen our awareness through critical reflections. A review of the literature and the imagination were used, combined with dialogue with colleagues. These helped us become aware of other aspects previously unknown to us and gave us a deeper understanding of what it means to live in the world of an asylum seeker and their experiences of dignity when undergoing the health examination.

### Ethical considerations

The study followed the principles stated in the Declaration of Helsinki.[23] Before the onset of the study, it was approved by the NSD (Norwegian Centre for Research Data)[24] under project number 59689. Each of the participants received a letter of information about the project and a consent of participation form before the interview. The confidentiality of the interview was also specified to both the participants and the interpreters. It was emphasised that participation was voluntary and the participants were required to sign a consent of participation form. In presenting the results, the anonymity of the participants is maintained by using fictitious names. The recorded interviews and transcripts were stored in accordance with the relevant regulations.[24]

## Results

The *naïve understanding* reflected how the participants' lived experiences of dignity during the health examination varied. Their understanding of dignity was mainly described by virtues. Undergoing a health examination entailed the uncertainty of being treated with dignity. The participants expressed a positive experience resulting from nonverbal communication, such as a smile or touch. However, inadequate information and communication resulted in experiences of anxiety and apprehension. Some of the participants conveyed experiences of satisfaction in centres and situations where they received adequate attention and treatment, while others expressed experiences of being met with indifference due to what they observed as a high level of activity, thus giving them the impression of a chaotic situation.

The *structural analysis* of the lived experiences of dignity during health examination can be embodied in four themes: uncertainty and insecurity inhibited dignity, comfort was crucial for dignity, language barriers influenced dignity and the organisation affected dignity.

### Uncertainty and insecurity inhibited dignity

Due to the turmoil and insecurity involved in fleeing from a country and seeking asylum, security and a better life and possibilities in a new country, the participants' anxiety built up around how they would be received, including at the health examination. This anxiety was related to their understandings of dignity, a sense of freedom and independence, having a good job and a distinguished position.

> Dignity is first and foremost freedom. 'Jamal'

The freedom to do and become what one wants in life was considered worthy. According to the participants, the experience of uncertainty was overwhelming when they realised that they had to undergo a health examination that is partly compulsory (tuberculosis screening). Some of the participants admitted that it took a while and a lot of convincing from other asylum seekers before they decided to go to the health centre for the examination. 'Raul' kept thinking:

> What if I answer incorrectly? Will they send us back?

They were also concerned that prejudice would be a barrier to receiving good health services and would be a contributing factor to poor treatment. Some of the participants anticipated that healthcare personnel would be focusing on the political and current situation in their country. 'Sarah' was surprised:

> They did not ask me about my political standpoint.

Coming from a country at war, asylum seekers hoped to be in a safe environment and receive good and equal treatment. According to the asylum seekers, the dignity of the healthcare personnel was associated with considerable responsibility and knowledge of justice, and thus possessing qualities deserving of respect. One of the participants had a very tragic experience, which made her unsure about the healthcare system.

> I was pregnant (third trimester) when we arrived in Norway. The healthcare personnel did not believe me

> when I told them something was wrong with my baby. The following day, my baby was stillborn. 'Sarah'

The asylum seeker wished to be treated with dignity, i.e. respect, kindness and understanding, so that she could once again trust her environment and the people in it.

### *Comfort was crucial for dignity*

The participants repeatedly said that they could still remember their first impressions from the first health examination. Half of the participants said that they were greeted with a smile, while the others were met with a poor attitude and behaviour among health professionals.

> There are some health professionals who were not kind, but there were also many who were. Some gave the kids toys so the kids stopped crying. Other places, we were served coffee. 'Sadik'

Demeaning behaviour on the part of some of the healthcare personnel provided the participants with an experience of unworthiness. The participants said they felt unwelcome. Healthcare personnel overlooked them and showed a minimum of interest in them. They were indifferent, according to most of the participants.

> I was very grateful when I arrived in Norway. I did not pay much attention to how I was treated. Of course, I was also confused, frustrated and angry. It felt like they looked down on us. 'Ari'

Most of the participants said that kindness provided an experience of respect. Good behaviour and good morals are associated with dignity. Dignity also involves a good relationship by learning, having and showing good virtue, i.e. respect, wisdom and integrity. They also compared dignity with credibility, wisdom, power and courage. A person's behaviour, they believe, reflects the person's inner self. 'Ahmed' still remembers a nurse who walked over to him as if she wanted to comfort him.

> A nurse came over to me and patted my arm. I would be afraid to touch a person coming from a war-torn country, but this nurse was not afraid. I think it was courageous of her. 'Ahmed'

This action made 'Ahmed' experience kindness and care. 'Ahmed' reflected on this by saying that sometimes not saying anything says it all. He thought a smile was more than enough. He also believed that the physical pain from the health examination can be quickly forgotten, but the experience of care remains.

### *Language barriers influenced dignity*

According to the participants, communication was very challenging and tiring, and the language barrier comprised a critical aspect during the health examination. Translation takes time and patience, both for the asylum seeker and healthcare personnel involved. Due to the lack and/or absence of information, the participants were curious about what was happening around them. Several of the participants wished that an interpreter had been available during the entire process. Not understanding what they were being told resulted in experiences of uncertainty and insecurity.

> I wished there was an interpreter. When I do not understand what others are telling me, I become scared and insecure. 'Ari'

Although the participants were aware of the importance of an interpreter, none of the participants could deny that the presence of an interpreter posed a challenge during the health examination. They felt that they could not speak freely and honestly because of the third person, i.e. the interpreter.

> I admit, I could not tell everything and sometimes I did not answer truthfully. It felt wrong to hand over a lot of information to a person other than healthcare personnel. 'Ahmed'

The participants experienced that the presence of an interpreter during the health examination made the conversation quite impersonal and formed a barrier in itself. The confidentiality of the conversation was not the challenge, but rather the experience of disclosure to third parties during the conversation. For asylum seekers, the disclosure of information through an interpreter was considered a violation of their integrity. The conversation should be between them and the healthcare personnel. The situation made asylum seekers feel trapped in despair, giving them experiences of hopelessness, while at the same time they fully realised that communication could not take place without an interpreter. Even with the use of an interpreter, the participants mentioned that special expressions and local terms used in their country posed an interpreting challenge. Sometimes the translation was so difficult that the participant and interpreter agreed not to translate or to use an alternative translation, which made the situation very frustrating, both for the asylum seeker and the healthcare personnel. Although the use of an interpreter could sometimes be a barrier, asylum seekers acknowledged the benefit of using one. For them, understanding the process of the health examination outweighed the sense of personal intrusion, giving them a partial experience of security in a very uncertain situation.

### *The organisation affected dignity*

Most of the participants observed that, in several places, the surroundings were uncomfortable and there were episodes of chaos and high activity levels that made them uneasy. Healthcare personnel hurried from one patient to another and talked to different staff members about many different things. Most of the participants mentioned

that the healthcare personnel very often overlooked them, which they experienced as demeaning. They also went through a considerable amount of waiting in order to undergo the health examination.

The presence of numerous personnel and the frequent transfer and movement from one place to another made the participants experience confusion and triggered feelings of insecurity.

> There were a lot of people who were working at the centre when we arrived. Most of them were kind and made us feel safe. But we were moved from one place to another in such a short time, which made the situation confusing. 'Jamal'

The participants also observed that some healthcare personnel seemed unsure about what they were doing and very often had to receive help from other healthcare personnel while performing the health examination.

Some participants observed that, at health centres with a structured and well-organised system, the atmosphere was calmer and the healthcare personnel friendlier. This contributed to experiences of security and respect. The healthcare personnel had time to talk to asylum seekers and provided equal treatment.

## Comprehensive understanding and discussion

The comprehensive understanding involved discourse on the literature. This helped us interpret asylum seekers' lived experiences of dignity during the health examination by way of a pattern consisting of four categories: rights-related, care-related, communication-related and system-related. In this study, we integrate the comprehensive understanding and the discussion.

### *The rights-related category*

Asylum seekers accepted and underwent the health examination, some for fear of being sent back. However, the participants experienced uncertainty as to whether the information obtained during the health examination would be used against them during the processing of their asylum application. The fear of deportation is also evident in previous studies.[4,12] The fear of being sent back was closely linked with their understanding of dignity, which is very much in accordance with the Declaration of Human Rights.[1] Being an asylum seeker involves seeking security and freedom, i.e. a dignified life.[25] The health examination was considered a threat to this. In a study by Suurmond et al.,[26] participants emphasised the importance of informing asylum seekers that undergoing the examination would not affect their asylum application.

### *The care-related category*

The dignity that the participants associated with healthcare personnel refers to the moral commitment found in the ethos of nursing.[15,27] However, the tragic experience of the pregnant woman who lost her baby shows us that the nurses and other healthcare personnel did not act in a dignified way according to their ethos. They did not believe her and, consequently, did not handle the situation according to professional or ethical standards. Unattended health needs is a common occurrence during health examinations,[4,6] the focus of which is mainly on identifying communicable diseases, while actual needs are overlooked.[4] Losing a child is highly traumatic and can cause severe suffering. In this case, the trauma was due to the fact that the nurses or other healthcare personnel did not take her concerns seriously. According to Jacobson,[28] this is a common form of dignity violation.

The participants associated the healthcare personnel's dignity with good behaviour and good morals. Their descriptions of dignity as virtue are in accordance with the categories established in Nåden et al.'s model 'When nursing becomes an art'.[27] Sadly, the encounters with nurses and other healthcare personnel did not always coincide with the participants' expectations. Jacobson[28] argues that dignity-violating behaviour leads to experiences of unworthiness, unwelcomeness and indifference, and often happens when there is asymmetry in the encounter and one of the actors is in a position of vulnerability. According to Luiking et al.,[5] personnel tend to perceive asylum seekers as 'others', and some healthcare personnel consider asylum seekers to be a burden on the healthcare system.[29]

Edlund[17] and Nåden and Eriksson[27] stress that dignity in nursing must emphasise both the substance and style of nursing care, both in what is done and how it is done. In order to provide dignified nursing care, one must start by recognising inherent dignity.[17] Human beings seek meaning and acknowledgement of their existence, including a caring relationship in which one can give and share love and hope.[30] We can always try to relieve suffering and comfort the patient through small acts of kindness and thus enhance dignity.[31] 'Ahmed's encounter with a nurse is an example of this. Eriksson[16,30] emphasises that being in a dignified caring relationship may reduce suffering and promote health.

### *The communication-related category*

Communication problems are common when asylum seekers interact with nurses and other healthcare personnel.[3–6,8,32] For the participants, communication problems and the insecurity and fear accompanying them entailed more or less a loss of integrity and autonomy and were therefore a threat to their dignity. Autonomy can especially be threatened because communication problems reduce the possibilities for informed decision-making about one's own health.[3]

The participants were largely dependent on an interpreter. Without one, they would be 'voiceless'. A previous study reported that using an interpreter was experienced as a problem.[33] Poor and incorrect interpretations and misunderstandings can form an obstacle to identifying health problems and symptom reporting and may lead to a higher

risk of inappropriate nursing care and medical treatment.[3,4]

Asylum seekers do not always trust the interpreter's confidentiality and are suspicious about the interpreter's ability to be objective.[32–34] The participants in this study stated that confidentiality was not the problem, but that they experienced that they could not speak freely and honestly due to a fear of disclosure to a third party. Feelings of shame and the fear of stigma can be underlying reasons for a lack of willingness to disclose information when an interpreter is present.[8,12,33]

Language and culture are intertwined. Using an interpreter who did not know the participant's language and culture well caused problems and inadequate communication. This was also evident in Hadziabdic and Hjelm's[33] study. When an interpreter has the same origin, religion, dialect, gender and political views as the asylum seeker, this leads to feelings of confidence.[33]

Despite the challenges, using an interpreter was also beneficial and the participants stated that using one resulted in experiences of security. These findings are in accordance with Hadziabdic and Hjelm's[33] study.

### *The system-related category*

Dignity was affected by the organisation and physical locality of the health examination. According to Jacobson,[18,28] unpleasant settings as described by the participants are more likely to cause dignity violation. The participants were moved from one place to another and had to relate to numerous personnel, resulting in experiences of confusion and insecurity. Experiencing such unpredictable environments may lead to post-traumatic stress reactions.[9] On the contrary, the experience of being in control of a situation contributes to dignity.[18]

During the time when the participants arrived in Norway, there was a large influx of asylum seekers and many communities had difficulty finding suitable health examination locations and qualified healthcare personnel.[35] The participants' observations of chaos and the fact that the healthcare personnel often had to request help from others are supported in a previous study,[35] which also found that most of the healthcare personnel working with asylum seekers lacked experience and knowledge about migration.

It seems that there is a great deal of potential for a better organisation of the health examination. How nurses organise this and how they use the asylum seeker's time either show respect or, conversely, fail to show respect. Edlund et al.[13] argue that organisation is a question of aesthetic dignity. In order to ease asylum seekers' concerns, safeguard good quality services when conducting the health examination and save time, a work tool that keeps track of important information, such as where, when and which health services have been provided, can be helpful.[35] Being overlooked and having to wait a long time are dignity-violating elements that may contribute to experiences of indifference, intrusion and objectification.[28] Eriksson et al.[36] argue that not being seen may contribute to feelings of shame and guilt and, consequently, violated dignity.

However, some participants expressed that, in places where there was a structured organisation of health examinations, they experienced security and respect, and were both seen and spoken to. Being met with dignity is fundamental to good health[17] and may therefore help the asylum seeker better face the challenges associated with being an asylum seeker.

### *Methodological considerations*

This study has several limitations. A small purposive sample of participants may jeopardise transferability. The NSD[24] advised us to not explicitly collect demographic data from the participants, so we have little information about their backgrounds. Using an interpreter during interviews may have influenced the findings, both positively and negatively. The use of an interpreter allowed the participants to respond in their own language, giving them the possibility to express themselves better. But without the need for an interpreter, more sensitive data might have been disclosed. And, most likely, the interview situation would have been a smoother process for the participants. The first author carried out the interviews because she was familiar with the context and had the right skills and experiences to interact with both asylum seekers and interpreters. Lindseth and Norberg[21] emphasise the phenomenological attitude and the need to put our judgements into brackets. Familiarity with the clinical context was an advantage, but also posed a challenge in being open to the meaning of the participants' lived experiences. Bracketing was of course also necessary for the second author. We conducted only one interview with each participant. Had we returned to the participants for a second interview, we could have presented and discussed the data collected and achieved a deeper and more nuanced understanding of their lived experiences. All of the participants were classified as refugees when the interviews were conducted. Their experiences may differ from those of current applicants and those whose applications were rejected. Quotations were used to validate the results. Both authors contributed to the data analysis, and we believe that the discourse helped us to a deeper understanding of the meaning of the text.

## Conclusions

This small study has limitations in terms of the conclusions that can be drawn. The study implies that asylum seekers' lived experiences of dignity during the health examination can be linked to dignity violation, as well as dignity safeguarded. The results can be understood within the context of four main themes that reflect the uncertainty and insecurity experienced, that language barriers can inhibit the experience of dignity and that comfort and proper organisation can enhance the experience of dignity. It is therefore important that asylum seekers' basic human rights are recognised and protected. Their need for security and

care implies a link to the ethical imperative of dignity. Communication can be a double-edged sword in relation to dignity, which is why clear and distinct communication must be prioritised. A well-organised health examination process can be a way to show respect to asylum seekers. Based on the findings, it can be assumed that having sufficient resources, such as access to nurses and other healthcare personnel with ethical awareness and expertise in asylum seeker health and migration, dedicated and authorised interpreters, clear and distinct information about the health examination, adequate time and a satisfactory locality, can contribute to enhancing the dignity of asylum seekers during the health examination.

Asylum seekers are a large heterogenic group and more research is needed on the lived experiences of dignity during the health examination for sub-groups of asylum seekers. There is also a need to explore the lived experiences of safeguarding asylum seeker dignity during the health examination of nurses and other healthcare personnel.

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## Conflict of interest

The authors declare that there is no conflict of interest.

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