Current Issues and Future Possibilities for Improving Healthcare for Migrant Women in Slovenia

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The research's purpose was to study the social integration of migrant women in terms of their reproductive health in relation to the healthcare system in Slovenia. The survey was based on 52 migrant women treated in a Slovenian hospital for female diseases and obstetrics between March and September 2018. Data were collected using a questionnaire that included questions on language knowledge and barriers related to communication, discrimination and violence against migrant women. Basic descriptive statistics were used and the results are presented in frequencies and percentages. For issues where the respondents were free to answer, the results are shown by the frequency of occurrence. Health services have the same task with regard to migrants as they have for the rest of the population, i.e. to provide them with accessible and high-quality care, as well as health promotion and education. Based on the results of this research, it is evident that one of the biggest problems perceived is 'language barrier,' referring to both respondents as users of the healthcare system and the healthcare system in Slovenia as such. In rare cases, respondents reported intolerance had been shown by healthcare professionals.

Introduction

Migration studies have in recent decades become a vibrant discipline due to the effects of increasingly dramatic migration waves, the economy, society

and, last but not least, over-congested and undernourished health systems (Cox & Marland, 2013). According to Josefová (2014), we are living in a stage of the world where whatever happens affects everyone, and the current situation Europe finds itself in concerns everyone who lives here. She also believes the issue of immigration has several solutions available. One solution is mutual tolerance and the search for compromise, such as acceptance of the language used by minorities and the need for elementary education in the language of the culture of the host country. Of course, this also establishes bilingualism, which brings diversity and plurality (Josefová, 2014). Multicultural societies are made up of people from different backgrounds who face life on a day-to-day basis amid cultural diversity. It is therefore important to understand the attitude to multiculturalism from the perspectives of the ethnic majority and members of minority groups (Rechel et al., 2006). It is also essential to understand that life in a multicultural society does not mean that one culture is better than another, because openness, mutual respect and tolerance lead to the better coexistence of people in any multicultural society (Josefová, 2014). The increasing diversity of populations in Europe is creating new challenges for health systems that then need to be adapted to remain responsive (Rechel et al., 2011).

The reasons women migrate are similar to those motivating men, and as numerous. However, they are made vulnerable by their characteristics, expectations and stereotypical performances in the cultural environment. Thus, they are also subject to inequality and discrimination, which affects their health status (O'Neil, Fleury, & Foresti, 2016). Therefore, any consideration must take account of all aspects and characteristics of cultural practices, traditions and behaviour. Depending on cultural beliefs and values, a particular culture may hold deep-rooted beliefs about the concept of illness and healing. Health professionals must therefore also have the necessary knowledge and skills to be able to treat patients of different cultures appropriately.

Methods

Study Design

The study forms part of the INTEGRA project (INTERREG programme V A Italy–Slovenia 2014–2020) concerning migrant women's characteristics, their sexual and reproductive health and social integration into both Italy and Slovenia. The research purpose was to investigate the process of the social integration of migrant women in terms of their reproductive health within the healthcare system in Slovenia. For the study's purposes, a combined quantitative and qualitative design was used.

Sample

In this study, convenience sampling was applied to migrant women who had been treated in a Slovenian hospital for female diseases and obstetrics between March and September 2018 as either an ambulatory or hospitalised patient. Participation in the study was voluntary. The study only included adult migrant women older than 18 years.

The convenience sample encompassed 52 migrant women. The participants' average age was 32.46 (s = 8.06). The youngest was 19 and the oldest 56 years. The average age of the participants when arriving in Slovenia was 27.53 (s = 7.25) years; the youngest participant was 17 and the oldest 53 years. Most participants (n = 32; 61.5%) had migrated to Slovenia within the last 5 years (2014–2018). The length of their stay in Slovenia varies from 1 to 15 years (average = 4.16 years, s = 7.25).

Most participants come from the former republics of Yugoslavia (n = 36; 69.2%) or Russia (n = 11; 21.2%).

Instrument

The research instrument used was a semi-structured questionnaire developed by the lead partner (University of Trieste in association with the Burlo Garofolo Pediatric Institute) and submitted in January 2018 (16.1.2018; 12:11). The Italian version of the questionnaire was translated into the Slovenian language, adapted to the Slovenian cultural context, and aligned with the healthcare system established in the Republic of Slovenia. Besides the sociodemographic part, the questionnaire contains 69 items which are related to the social integration of migrant women in the host country, and their sexual and reproductive health. For the purposes of this paper, only relevant issues were analysed.

Data Collection Procedure

The survey was conducted from March to September 2018. The questionnaire was distributed with the assistance of hospital staff also involved in the project.

Oral informed consent was obtained. The participants' confidentiality and anonymity were ensured. All participants were informed about the aims, objectives and study methods used. The study was conducted in accordance with the Helsinki-Tokyo Declaration and the Code of Ethics for Nurses and Nurse Assistants of Slovenia. The study was approved by the National Medical Ethics Committee (26.10.2017; 0120-544/2017/7).

Table 1 Socio-Demographic Characteristics of the Respondents

Variable		*n*	%
Country of birth	Bosnia and Herzegovina	16	30.8
	Croatia	2	3.8
	Kosovo	5	9.6
	FYR Macedonia	9	17.3
	Russia	11	21.2
	Slovakia	1	1.9
Religion	Catholic	2	3.8
	Protestant	2	3.8
	Muslim	19	36.5
	Orthodox	26	50.0
	Other	1	1.9
	Not a member of any religion	2	3.8

Data Analysis

Data were processed and analysed using SPSS version 22. Basic descriptive statistics were used with the calculation of frequencies and percentages. For issues where the respondents were free to answer, the respective units of words were ranked and shown by the frequency of occurrence.

Results

The results are presented in three sections. The first part shows some socio-demographic data on the respondents. The second section relates to the language of the host country and the obstacles encountered by the respondents. In the third part, certain issues referring to discrimination and the difficulties migrant women encounter are outlined.

Socio-Demographic Data

Table 1 summarises selected socio-demographic characteristics of the migrant women participating in the study. Most are from the former republics of Yugoslavia or Russia. Half the participants stated they are members of the Orthodox Church, followed by the members of Islam.

Regarding their current employment status in Slovenia, 28 respondents indicated they are unemployed or stay at home to run the household and 24 women stated that they are working. Respondents often stated their reason for moving to Slovenia was to join a family member who was already living in Slovenia. A similar share mentioned marriage or work as the reason for moving to Slovenia. Only two respondents stated their reason for coming to Slovenia was to study (Table 2).

Table 2 Socio-Demographic Characteristics of the Respondents

Variable		*n*	%
Employment status in the host country	Housewife	17	32.7
	Unemployed	11	21.2
	Employed	24	46.1
Reasons for moving to Slovenia	Work	11	21.2
	Study	2	3.8
	Joining a family member	29	55.8
	Marriage	10	19.2

Table 3 Knowledge of the Language of the Host Country

Question		*n*	%
Do you speak Slovenian?	No	6	11.8
	A little	22	43.1
	Fairly well	12	23.5
	Very well	11	21.6
Have you attended any form of formal or non-formal education in Slovenia?	Language course	20	42.6
	Professional training course	5	10.6
	Education in schools	3	6.4
	None	19	40.4

Host Country Language Barriers

Respondents were asked if they speak the Slovenian language and also if they had participated in any form of education in Slovenia. The results are shown in Table 3. In response to the question of whether they would attend advanced courses in the Slovenian language, 24 (46.2%) respondents did not answer. Out of the remaining answers, 24 (46.2%) stated they would attend some language training, and just 4 (7.7%) indicated they would not attend such forms.

Violence, Discrimination and Language Issues

The respondents were asked whether they had ever encountered violence and discrimination in healthcare institutions. Table 4 shows they had rarely encountered discrimination, while 8% had experienced violence. According to the last question, some respondents also gave their answer in written form. Most of them stated that they had no problems, then the answers that follow (by frequency) relate to (mis)understanding of the language. A couple stated they had difficulty arranging matters at the administrative unit. For the question on where they see the main problem in communication between

Table 4 Presence of Violence and Intolerance

Question		*n*	%
Have you ever experienced any form of violence in a healthcare institution?	Yes	4	8.0
	No	46	92.0
Have you ever experienced any form of discrimination in a healthcare1institution?	Yes	1	2.0
	No	50	98.0

healthcare professionals and patients of other cultures, 38 respondents submitted their answers in written form.

The answers were ranked by frequency of occurrence. The majority of respondents stated the main problem/reason is the language barrier ($n = 32$). Another group of respondents said they did not see any particular problems, thereby disregarding this as an issue of weight.

The question as to what should be done in the future to improve the relationship between healthcare professionals/institutions and patients from other countries was answered by 28 respondents. Half of them stated they do not know ($n = 14$), a larger proportion of the remaining half respondents expressed the belief that it´s necessary to provide more interpreters/translators in clinical environments. Others said there should be more staff available who either speak other languages or even come from other countries.

Discussion

The results show that most of the migrants come from the former Yugoslav republics or Russia. Moreover, half the respondents are members of the Orthodox Church, followed by members of Islam. Culture not only includes ethnicity and religion, but also socio-economic factors such as level of education, housing conditions and access to information (Durieux-Paillard, 2011). All of this, of course, affects their assimilation into society and their perception of the world and the culture of the country in which they are attempting to build a new life.

The study shows a relatively low understanding and/or speaking of the Slovenian language among the respondents. Further, no desire is expressed for education in this area or for improving language skills. This is seen in the fact that half the respondents did not answer when asked if they would like to attend an advanced Slovenian language course.

It is encouraging that the respondents have not often experienced discrimination in the health system, nor encountered violence or discrimination in healthcare institutions. Yet the finding that 8% of the respondents

reported they had experienced violence in health facilities should be taken seriously. Individuals may also have different criteria and different desires for health and healthcare (Clarke, 2017) and that may also be an issue to consider.

It should also be recalled that inequality, as O'Neil, Fleury, and Foresti (2016) state, causes the expectation that women are responsible for unpaid domestic care and responsibilities. This aspect also significantly affects and intersects with inequality and discrimination.

Most respondents stated they had not encountered any problems in a healthcare institution. Throughout the questionnaire, the respondents constantly indicated serious difficulties are present. And those difficulties are mostly related to (mis)understanding of the language. Respondents frequently mentioned suggestions to provide more interpreters/translators in clinical environments. Some also stated there should be more staff who either speak other languages or even come from other countries and cultures. There is also extensive evidence showing the importance of ethnic, religious and linguistic factors that affect socio-economic factors and that problems which arise are both language barriers and the lack of relevant information and resources for migrants (Durieux-Paillard, 2011). Respondents frequently mentioned suggestions to provide more interpreters/translators in clinical environments and healthcare settings. Some also said there should be more staff available who either speak other languages or even came from other countries. This, in fact, also acts as a call for both the state and the political sphere to move in the direction of solving such problems so as to meet the needs of migrants. Ingelby (2011) highlights and indicates interactions in healthcare, where a variety of methods are proposed to overcome language barriers:

- *Professional face-to-face interpretation* as one of the most accurate methods, but with many drawbacks. It is an expensive method. Patients sometimes also do not want the presence of a third person because they fear that intimate details will not be kept confidential (especially if the translator come from the same community);
- *Professional interpretation by telephone* where the interpreter is not physically present, with this able to solve a number of logistical and cost problems. The disadvantage is that this method has fewer visual cues, despite technological progress;
- *Informal face-to-face interpretation* where reliance on family members (especially children) may impact on the confidentiality of the meeting

and can be emotionally difficult for those involved. Sometimes, an employee at the medical institution who speaks the same language can take the place of an interpreter. The main concern in conjunction with informal interpreters is that they simply do not have the skills and specialised vocabulary required to avoid any possible misunderstandings in medical treatment;
- *Bilingual professionals* who know the patient's language have numerous advantages over the abovementioned methods;
- *Cultural mediators* are professionals who not only provide a linguistic explanation, but also actively mediate among healthcare professionals and patients. They attempt to overcome not only language barriers, but cultural and social barriers as well. This method has many advantages and the role of 'cultural mediator' can be diverse and comprehensive. The main problem of this method is payment. Some countries provide state subsidies for interpreting and translation services, while others require service providers to pay.

The chief aim of intercultural healthcare is to ensure culturally harmonious care that meets the individual's lifestyle, values and value system. Recognition, respect and adaptation to the cultural needs of patients, families and communities are key elements of healthcare (Clarke, 2017) which seeks to prevent health inequalities. Cultural competence needs to be part of the overall skills, knowledge and attitudes of health professionals and they must be adequately trained if they are to provide appropriate care to a wide range of patients (Durieux-Paillard, 2011).

Narayanasamy and White (2005) mention in their research that healthcare professionals also have a stronger obligation to promote cultural competence in the direction of reducing racism and oppressive practices. Our multicultural society of the 21st century also encourages teachers and students to prepare themselves carefully to deal with their own differences, by developing their cultural competencies and increasing their intercultural awareness (Catana, 2014). Multicultural ideologies are not only support for cultural diversity, but are also important for enabling equal opportunities for all people (Rechel et al., 2006).

Conclusions

Every day, health professionals meet people from both the same and other cultural backgrounds. In the face of relatively rapid social changes, our healthcare system has remained fairly rigid and it is vital that both the sys-

temic and individual levels of healthcare are adapted to the currently expressed needs of the people entering this system. It is important that migrants who seek care in our healthcare system are given appropriate and adequate healthcare. This not only includes professional knowledge, but knowledge regarding other cultures and the needs of the people health professionals encounter on a daily basis. Finally, it is both necessary and humane to create an environment for everyone that is devoid of violence and discrimination.

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