EM BUSCA DE UM BOM MÉDICO QUANDO 'A SAÚDE NÃO TEM FRONTEIRAS'

Percepções dos Cabo-Verdianos sobre profissionais de saúde na Holanda.

SEEKING THE GOOD DOCTOR WHEN 'HEALTH KNOWS NO BORDERS'

Cape Verdeans' perceptions of health care providers in the Netherlands.

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Aos meus pais, Natália e António

Contents

LIST OF TABLES AND MAP

PREFACE

No borders and good doctors: A new style of health care?

Of the countless studies about immigrants and health care, few are dedicated to what immigrants themselves actually do to keep or regain their health. This study is one of them and offers the reader some useful insights in the reasons why immigrants sometimes do not want to use the health service of the country in which they live.

"Under-use" of health service by immigrants is considered as an important problem and is often ascribed to the lack of knowledge on the side of the immigrants, taboos and shame that relate to certain illness (for example mental illness) and other explanatory models of the immigrants. That "under-use" can be also related to the expectations and perceptions of the-patient-to-be is less acknowledged. Disappointment and perhaps disillusion with the nature of health services may be necessary factors in studies of immigrant health care.

This book focuses on what Cape Verdean immigrants in the Netherlands consider to be a "good doctor". Most of us are familiar with the doctor's idea of a "good patient". Good patients are compliant with therapeutic regimens, they do not lie about taking medicines or in reporting symptoms, they are patient when having to wait in a low row for an appointment, they understand that medicine has limitations, they accept the authority of the health professional, and – for example in the Netherlands – they know how to negotiate with their doctors about the pathways and therapies to follow. There is, however, a striking similarity between a good patient and a good doctor.

The "good doctor" whom the Cape Verdeans describe comes close to the doctor Winkler has described in his La Maladie du Sachs. Sachs wants to alleviate the suffering of his patients. He endlessly listens and is always approachable for his patients. Sachs, however, suffers probably as much as his patients. He uses morphine and his worldview is not optimistic: "Life is not happiness. Life is suffering and endless fuzz. The body knows better how to suffer than to enjoy." Sachs believes that to be a doctor is having to be mad: "Only lunatics want to save lives of others, they don't realise that it is impossible..." To be a "good doctor" sometimes means suffering.

I wonder if such expectations of the doctor are not something we all have when we become a patient. We want the doctor empathically listening to us, we want him (or her) to take time for our problems, and maybe we even want

him temporarily to take over our responsibility because we feel sick. Cape Verdeans are not very different. Their descriptions of a good doctor are similar.

This is not to say that doctors do not want to be good doctors nor to argue that patients do not want to be good patients. They both often fail. Both, doctor and patient are trapped in a complicated health care system. On the one hand, principles, such as "managed care" want us – the patients – to act as self-confident consumers who are perfectly able to negotiate and to select the health care that best suits us. On the other hand, both have to respect a set of standards and rules, which may constrain possibilities for the "good doctor" and the patient. When patients, such as immigrants, i.e. Cape Verdeans, do not have the skills to act like a good consumer-patient, because they are accustomed to a different way of doctoring, they might not meet a good doctor. This is not the doctor's "fault". Present health care systems result from present health policies and economic interests. It is at this point that we start to understand the links between the macro context and the micro level and the consequences for individuals in the health system when policies are implemented.

However, immigrants, perhaps to a larger extend than the native citizens of countries, are active agents and have some possibilities to find a "good doctor". Due to their international social networks and social ties with their homelands, they are able to find such a doctor elsewhere. They may travel to remote countries to find the desired health care.

Studies of such active health seeking will alter the existing scientific models of health patterns and health seeking behaviour that do not reckon with "internationalisation" and "globalisation" of health care from the point of view of patients. Classical models will not be useful in the future. When we think of globalisation in relation to health care, we mostly think of the spread of the so-called western medical system and its techniques over the world. One may argue, however, that "health without borders" is also a form of globalisation. It would be important to have more knowledge and understanding of what people do and how they use modern means of travelling and communication to find the "good doctor" they want. That will give not only an understanding of health perceptions and the ways people deal with suffering, but it will also show the transnational social and cultural relationships that have no borders today. This volume has certainly contributed to a better understanding of what people who are usually considered to live in the margin of societies such as the Netherlands do and how they seek their health.

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SUMMARY

Western countries have increasingly set out efforts to improve the quality of health care provisions for its multicultural populations. However, it is generally agreed that health and health care resources are not equally accessible to members of all ethnic groups. Effective development and provision of culturally competent health care demands for the inclusion of users´ perspectives on what good quality care entails. This piece focuses on the case of Cape Verdean immigrants in the Netherlands. By inquiring informants about their perceptions of what defines a good doctor and about their expectations of and experiences with health professionals, an attempt is made to bring insight on factors impairing the use of (mental) health care services. Three barriers hindering the access to health care have been identified: lack of information about the health services available, problems on the relationships with health care providers and difficulties in dealing with the conditionality of help. These problems are deeply intertwined and relate to two sets of factors. At the macro-level these include the organisational and structural characteristics of the Dutch health care system. At the micro-level, the problems concern a mismatch between users and providers' expectations regarding health care provision.

Despite the barriers encountered, Cape Verdeans strive to benefit from good heath. The informants of this study employ two sorts of strategies as a means to access good quality health care. On the one hand, they try to adapt their help-seeking behaviour to the model prevalent in the Netherlands. On the other hand, they resort to transnational health care use in other European countries, including Portugal and France. These strategies prove Cape Verdeans' resilience in finding the care that is most appropriate to their needs.

Key-words:
Cape Verdeans, health care use, good doctor, transnational health care seeking.

SUMÁRIO

Em especial nas últimas duas décadas tem-se assistido ao incremento de esforços por parte de alguns países no sentido de melhorar a qualidade dos serviços de saúde para as suas populações cada vez mais multiculturais. Contudo, continuam a observar-se diferenças entre grupos étnicos no que diz respeito a padrões de saúde e condições de acesso aos serviços disponíveis. Um relatório recente da Organização Mundial para as Migrações (IOM, 2005) alerta para a necessidade de se adoptar na Europa políticas de saúde integradoras e "culturalmente sensíveis". Isto é, políticas que visem o desenvolvimento e prestação de serviços de saúde sensíveis ao background social, cultural e religioso dos utentes. Como é defendido no mesmo relatório, este tipo de abordagem assume-se fundamental numa Europa cada vez mais multicultural e mais dependente de uma força de trabalho estrangeira activa e saudável.

Em linhas gerais, têm vindo a ser defendidas dois tipos de abordagens no que respeita à promoção de políticas e do acesso dos imigrantes aos serviços de saúde. A primeira tem vindo a assumir uma ideologia "assimilacionista", ou seja, é defendida a adaptação dos imigrantes aos cuidados de saúde existentes na sociedade de acolhimento. Já a segunda abordagem assume uma posição "multiculturalista" que defende a implementação de serviços adaptados às necessidades dos utentes de acordo com uma perspectiva sensível às diferenças culturais.

Um exemplo deste segundo tipo de abordagem é o caso da Holanda, onde foram criados serviços específicos para imigrantes, entre eles, um centro para a promoção de conhecimento sobre a saúde imigrante com "mediadores culturais". Neste âmbito, este trabalho procurou, a partir de estudos de caso de imigrantes cabo-verdianos, analisar os serviços de saúde da Holanda. Para este efeito, foram analisadas as perspectivas dos cabo-verdianos relativamente às características que definem um bom médico, assim como as suas expectativas e experiências com profissionais de saúde na Holanda. Ainda que o caso holandês seja um exemplo de uma abordagem "multiculturalista", no trabalho de terreno identificaram-se três barreiras no acesso de imigrantes aos cuidados de saúde: a falta de informação sobre os serviços de saúde disponíveis; problemas de relação entre utentes de origem imigrante e os profissionais de saúde; e, finalmente, dificuldades sentidas pelos os utentes imigrantes em lidar com a condicionalidade da ajuda prestada. Estes problemas encontram-se profundamente interligados e estão relacionados com dois tipos de factores. Ao

nível macro, estes incluem características organizacionais e estruturais do sistema de saúde holandês. Ao nível micro, os problemas encontrados derivam do desfasamento de expectativas entre cabo-verdianos e profissionais de saúde relativamente à forma pela qual os cuidados de saúde são prestados.

Apesar das barreiras encontradas, os cabo-verdianos não poupam esforços para beneficiar de boa saúde, colocando em prática duas estratégias com o objectivo de aceder a cuidados de saúde de boa qualidade. Por um lado, os cabo-verdianos tentam adaptar o seu comportamento enquanto utentes dos serviços (help-seeking behaviour) ao modelo prevalecente na Holanda. Por outro lado, recorrem ao uso de cuidados de saúde transnacionais noutros países da Europa, incluindo Portugal e França. Estas estratégias corroboram a perseverança dos cabo-verdianos em encontrar os cuidados de saúde que melhor se adequam às suas necessidades.

PART I - SUMÁRIO ALARGADO DA VERSÃO ORIGINAL

Em busca de um bom médico - quando a saúde não tem fronteiras

Introdução

A crescente diversificação cultural das populações residentes nos mais variados países europeus tem vindo a justificar a reformulação de políticas sociais, entre as quais se incluem as políticas de saúde. Nos últimos anos, alguns países têm mesmo promovido políticas multiculturais de saúde com o intuito de garantir a melhoria da qualidade e do acesso aos serviços de saúde. Apesar destes esforços, continuam a detectar-se diferenças na forma como os diferentes grupos étnicos acedem aos cuidados de saúde disponíveis. Distinguindo-se dos autóctones, os imigrantes e as minorias étnicas experienciam um acesso aos serviços de saúde condicionado por factores políticos, administrativos e culturais (Bollini e Siem, 1995). O idioma (Van Dijk, 1998; Sozomenou *et al*., 2000), a ausência de seguros de saúde (Wells *et al*., 2001) e o racismo (Fernando, 1993) são exemplos de barreiras que condicionam e distinguem esse acesso. Estas barreiras tendem a afectar predominantemente populações alóctones, levando frequentemente ao subuso de serviços de saúde necessários. Esta situação verifica-se também na Holanda, relativamente a alguns grupos étnicos, entre os quais se encontram os cabo-verdianos.

Este estudo aborda a questão do subuso dos serviços de saúde na Holanda pelos cabo-verdianos, partindo da análise do acesso desta população a esses serviços. Neste sentido, é primeiramente explorada a relação entre as necessidades de cuidados de saúde sentidas no seio deste grupo e o uso dos serviços disponíveis.

Quando comparados com a população autóctone na região de Roterdão, os cabo-verdianos evidenciam um estado de saúde mais débil e um índice mais elevado de problemas psicossociais (Huiskamp *et al*., 2000) (vd. quadro 1). Perante estas circunstâncias, seria de esperar uma maior utilização dos serviços de saúde (mental) por parte deste grupo. Contudo, esta relação não se confirma e cremos estar perante uma situação de subuso de serviços necessários. Os cabo-verdianos recorrem substancialmente menos a serviços de saúde mental do que a população autóctone (Dieperink e Wierdsma, 2000) (vd. quadro 2) e, de entre todos os grupos de imigrantes, são os que apresentam o menor índice de consultas com médicos de família (Huiskamp *et al*., 2000) (vd. quadro 3).

Quadro 1: Estado de saúde e problemas psicossociais experienciados por grupos de imigrantes em comparação com a população autóctone[1]

	Holandeses	Turcos	Marroquinos	Holandeses do Caribe	Surinameses	Mediterrâneos	Cabo-verdianos
Saúde Experienciada	1.00	.61	.77	.89	.86	.81	.81
Problemas Psicossociais Experiencia-dos	1.00	1.54	1.32	1.22	1.45	1.61	1.19

Fonte: Huiskamp et al. (2000).

Quadro 2: Uso de serviços de saúde mental em Roterdão*

		Holandeses	Turcos	Marroquinos	Surinameses	Holandeses do Caribe	Cabo-verdianos
1990	Homens	25.2	30.6	41.2	18.5	14.2	7.1
	Mulheres	35.2	37.4	16.5	18.7	9.8	9.5
	Total	29.7	33.1	30.7	18.4	11.8	**8.1**
1998	Homens	30	31.3	43.2	21.7	16.7	8.9
	Mulheres	46.1	47	32	29.7	18.8	22.6
	Total	36	36.7	36.2	24.6	16.9	**15.1**

* Figuras anuais por 1000 para utentes de serviços entre 20-64 anos, por sexo.
Fonte: Dieperink e Wiersdma (2000)

Quadro 3: Frequência relativa de consultas com o médico de família em Roterdão

	Holandeses	Turcos	Marroquinos	Holandeses do Caribe	Surinameses	Mediterrâneos	Cabo-verdianos
Consultas c/ Médico de Família	1.00	1.86	1.59	1.51	1.27	1.27	1.03

Fonte: Huiskamp et al. (2000)

Como poderá então ser explicado o subuso dos serviços de saúde (mental) pelos cabo-verdianos?

Existem vários motivos pelos quais os cabo-verdianos poderão não fazer uso dos serviços de saúde disponíveis. Primeiro, porque fazendo parte de uma comunidade muito unida – assente na solidariedade e numa forte rede

1. Estes dados são baseados na auto-avaliação e na percepção do estado de saúde e dos problemas psicossociais pelos próprios inquiridos.

social – os cabo-verdianos poderão não sentir a necessidade de trazer os seus problemas para fora da comunidade ou, poderão mesmo, ser pressionados a não o fazerem. No que diz respeito a este último aspecto, vários participantes neste estudo afirmaram que, muitas vezes, as pessoas não procuram ajuda por recearem ser alvo de intrigas na comunidade. Este receio parece ser mais premente no caso de doença mental, que continua a ser vista por muitos como um tabu.

O segundo motivo prende-se com o facto de que, os cabo-verdianos poderão beneficiar do seu próprio circuito de cuidadores (*healers*). Beijers (2004) evidencia a importância e a influência da religião, de seitas e de doutrinas filosóficas no processo de procura de ajuda (*help-seeking process*) dos cabo-verdianos, bem como o elevado valor atribuído a cuidadores capazes de prestar simultaneamente cuidados médicos e orientação espiritual. Este é o caso de um médico brasileiro acreditado e sediado em Paris que é, ao mesmo tempo, vidente. Vários cabo-verdianos residentes na Holanda, assim como noutros países europeus, visitam regularmente este médico.

Para além de irem a França, os cabo-verdianos consultam igualmente profissionais de saúde mental e médicos de família em Portugal e em Cabo Verde (veja-se De Ruuk, 2002; Beijers, 2004). Vários participantes neste estudo referiram aproveitar os períodos de férias nesses países para se consultarem com médicos. Ainda noutros casos, a procura de profissionais de saúde fora da Holanda assume-se como intencional e pragmática. O uso de serviços de saúde fora da Holanda é facilitado por redes sociais dos imigrantes cabo-verdianos, que não só lhes facultam informação sobre os serviços, mas também, os acolhem e apoiam durante todo o processo. Esta componente transnacional da imigração cabo-verdiana (Meintel, 2002) poderá assim constituir uma terceira explicação para o parco uso de serviços de saúde no país de acolhimento. As ligações a outros países e aos seus sistemas de saúde parecem trazer vantagens a dois níveis. Por um lado, o uso de serviços no exterior diminui a possibilidade de intrigas na comunidade já que a probabilidade de encontrar alguém conhecido é consideravelmente menor. Por outro lado, possibilita a comunicação num idioma mais familiar, como o português ou o crioulo.

Finalmente, o quarto motivo sugerido é o de que, os cabo-verdianos poderão fazer um uso escasso dos serviços disponíveis na Holanda porque estes lhes são inacessíveis.

Os serviços de saúde acessíveis a imigrantes são aqui definidos como serviços sobre os quais os imigrantes se encontram informados, dos quais sentem que podem fazer uso, e que os assistem e os tratam de forma adequada e satisfatória (Van Dijk, 2003). Isto traduz uma clara correspondência entre a ajuda prestada e as necessidades das pessoas que a procuram. Por outras palavras, serviços de saúde acessíveis são serviços que fazem sentido aos seus utentes (Ingleby, 2003a).

Objectivos e metodologia

Como foi referido, pretende-se com este estudo analisar o acesso dos cabo-verdianos aos serviços de saúde na Holanda e a forma como esse acesso poderá estar a influenciar a sua utilização. Para este efeito, inquiriu-se sobre as expectativas e as experiências dos cabo-verdianos com profissionais de saúde na Holanda. O objectivo final do estudo consistiu em determinar o que os cabo-verdianos consideram ser um 'bom médico'. Esta categoria pode ser usada para avaliar as características e as qualidades necessárias a um profissional de saúde de modo a poder facilitar o acesso a serviços de saúde de boa qualidade.

Dada a natureza deste estudo recorreu-se a métodos qualitativos. O trabalho de campo foi realizado entre Outubro e Dezembro de 2003, na região de Roterdão, onde vive a maior parte da população cabo-verdiana na Holanda. Foram realizadas entrevistas semi-directivas com sete utentes, cabo-verdianos de serviços de saúde (mental). Adicionalmente, foram conduzidas entrevistas com cinco informadores chave, assistentes sociais em associações ou organizações onde têm sido desenvolvidos projectos dirigidos à comunidade cabo-verdiana. Foi ainda realizada uma entrevista com um membro de uma organização de clientes, com o objectivo de reunir informação sobre a filosofia inerente à prestação de cuidados na Holanda.

Posteriormente, a partir da análise de conteúdo temática das entrevistas realizadas foi possível identificar temas chave que estruturaram o trabalho final: a relação com o médico de família e os profissionais de saúde mental, a ajuda incondicional, os encaminhamentos, o "bom médico" e recursos e práticas de saúde transnacionais. Estes temas são apresentados de acordo com os seguintes tópicos: expectativas sobre a performance dos profissionais de saúde, percepções sobre a performance dos profissionais, procura de cuidados de saúde transnacionais e o 'bom médico'.

Resultados

Durante as entrevistas tornou-se evidente que uma grande parte dos participantes detinham pouca informação sobre os serviços de saúde mental disponíveis na Holanda, o tipo de cuidados prestados e o modo como podem fazer uso deles.

Expectativas sobre a performance dos profissionais de saúde

Ajuda incondicional

Todos os participantes neste estudo tiveram experiências com sistemas de saúde noutros países antes de chegar à Holanda. À parte do sistema de saúde cabo-verdiano, vários participantes contactaram com profissionais de saúde em países como Portugal, França, Guiné e Itália onde viveram durante um período das suas vidas. Estas experiências influenciaram as expectativas sobre a performance dos profissionais de saúde na Holanda.

Uma das principais diferenças entre os sistemas de saúde, identificada pelos utentes entrevistados, é a de que tratamentos eficientes não são prestados imediata e incondicionalmente assim que o pedido de ajuda é feito. Vários participantes relataram que saíram de consultas com apenas uma prescrição de analgésicos como, por exemplo, Paracetamol. A prescrição deste analgésico surge como uma metáfora para tratamentos ineficientes, espelhando, aos olhos dos cabo-verdianos, o desinteresse dos profissionais de saúde na Holanda perante os doentes. Este facto é encarado com grande surpresa e desagrado, já que se assume em extrema contradição com a expectativa de que os profissionais de saúde deverão zelar sempre pelo melhor interesse dos doentes.

Contudo, à medida que os participantes se tornam mais experientes no contacto com profissionais de saúde na Holanda dão-se conta que o "tratamento Paracetamol" pode ser convertido num tratamento específico, satisfatório e apropriado às suas necessidades. Para que esta mudança de atitudes se verifique torna-se imprescindível uma demonstração de que o seu estado de saúde implica de facto cuidados. Na verdade, vários participantes sentiram a necessidade de convencer os profissionais de saúde da seriedade e da gravidade dos seus problemas.

Percepções sobre a performance dos profissionais de saúde

Relação com o médico de família[2]

Mais de metade dos participantes descrevem a relação com o médico de família como problemática. O principal motivo destes problemas reside no curto tempo reservado à consulta com estes profissionais. Na Holanda, a duração das consultas com o médico de família raramente ultrapassa os dez minutos. Este facto é vivido com profunda indignação e descontentamento já que muitos participantes sentem dificuldades em explicar os seus problemas em tão pouco tempo e perante a pressão para que as consultas terminem. Nestas circunstâncias, o diagnóstico médico assume-se uma tarefa difícil. Vários participantes colocam em causa o rigor dos seus diagnósticos e alguns sentem que nem sempre são informados de todos os detalhes relativos ao seu estado de saúde. Esta situação mina a confiança nos médicos de família, levando alguns participantes a expressarem a convicção de que somente se conseguem certificar do seu 'verdadeiro' estado de saúde fora da Holanda.

Uma boa relação com o médico de família é condição fundamental não só para a obtenção de cuidados de saúde primários, mas também para o acesso a outros serviços já que estes profissionais assumem a função de *gatekeepers* do sistema. Dadas as dificuldades sentidas, alguns participantes mostraram o desejo de trocar de médico de família. Esta é uma opção altamente improvável dada a escassez deste tipo de profissionais na Holanda. Outros participantes sugerem como alternativa a adaptação do seu comportamento enquanto utentes às expectativas dos médicos, procurando ser mais concretos e directos na forma como comunicam os seus problemas ou fazendo-se acompanhar de alguém que lhes possa prestar assistência e/ou mediar o encontro, o que inclui, por vezes, apoio à tradução dos seus problemas para o neerlandês.

Encaminhamentos

Quase todos os participantes consideram difícil a obtenção de consultas com especialistas. Como foi referido anteriormente, o encaminhamento para especialistas depende dos médicos de família.

1. É importante referir-se que os médicos de família na Holanda assumem a função de gatekeepers do sistema de saúde, ou seja, a consulta com qualquer outro profissional de saúde só é possível através do encaminhamento do médico de família.

Na Holanda, tende a prevalecer uma filosofia de 'espera atenta' (*watchful waiting*), ou seja, a intervenção médica só é levada a cabo perante a certeza de que não se está na presença de um problema de saúde que desaparece ao fim de algum tempo, quer seja ou não aplicado tratamento. Neste sentido, o encaminhamento para especialistas surge condicionado pela manifesta seriedade dos problemas.

Vários participantes sentiram necessidade de negociar o uso de serviços especializados com os seus médicos de família. O sucesso deste processo de negociação depende de três factores: 1) a exposição do problema de forma clara e coerente; 2) a demonstração da seriedade do problema; e 3) a formulação do pedido de encaminhamento. Muito embora alguns participantes beneficiem dos encaminhamentos que julgam necessários outros há, porém, que se vêm confrontados com a impossibilidade de levar a bom fim este processo de negociação. Nestes casos, emergem frequentemente sentimentos de vulnerabilidade. A confiança nos médicos de família é também mais uma vez posta em causa.

Relação com os profissionais de saúde mental

Alguns participantes afirmaram que os problemas de saúde mental são considerados por muitas pessoas no seio da comunidade cabo-verdiana como um tema tabu. Dadas estas circunstâncias, é difícil a disseminação de informação relativa aos serviços de apoio existentes. A maioria dos participantes neste estudo declarou ter pouco conhecimento acerca de serviços de saúde mental. De entre os quatro participantes que declararam fazer uso deste tipo de serviços apenas um os procurou por sua própria iniciativa. Nos outros três casos o acesso aos serviços de saúde mental foi mediado por outros profissionais, nomeadamente assistentes sociais.

O estabelecimento de uma boa relação com profissionais de saúde mental encontra-se dependente da capacidade destes em se mostrarem disponíveis e atentos – dando tempo ao cliente para que este se sinta confortável e seguro. A confiança é um elemento chave para criação deste tipo de relação podendo levar um tempo considerável até ser adquirida. Nalguns casos, até que este tipo de relação fosse criada, os participantes recorreram à companhia de pessoas da sua confiança durante as sessões de terapia. Noutros casos, dada a falta de apoio garantida por este tipo de 'mediadores' e o escasso conhecimento acerca do modo como se processa habitualmente a terapia, surgiram dificuldades não só na relação com os profissionais de saúde mas também, com a aceitação do tratamento e medicação prescritos.

Procura de cuidados de saúde transnacionais

Recursos e práticas de saúde transnacionais

Usufruir de um bom estado de saúde é considerado uma prioridade por todos os participantes e um objectivo a alcançar, para o qual não devem ser poupados quaisquer esforços. Tal como foi referido anteriormente, alguns dos participantes sentem que o que eles identificam como bons cuidados de saúde nem sempre são prontamente prestados na Holanda. Dadas estas circunstâncias, alguns participantes tentam adoptar um comportamento de procura de cuidados (*help-seeking behaviour*) em maior consonância com as expectativas dos profissionais de saúde, na esperança de obter acesso a serviços de boa qualidade. Outros, porém, sentem a necessidade de complementar os cuidados recebidos na Holanda com cuidados de saúde noutros países da Europa. O benefício de um bom estado de saúde é sentido como uma razão, mais do que suficiente, para que se transponham fronteiras ou potenciais barreiras de língua, cultura ou informação.

Alguns dos participantes recorrem com certa frequência a serviços de saúde em França e Portugal. A confiança nos sistemas de saúde francês e português deriva do conhecimento sobre o modo de funcionamento dos serviços e de experiências positivas passadas com profissionais de saúde desses países. Existem ainda outros dois factores relevantes para que o uso destes serviços se torne possível. Por um lado, a perpetuação dos seguros de saúde em França e/ou em Portugal garante o direito ao uso desses serviços com custos relativamente suportáveis. Por outro lado, as fortes redes sociais que estes participantes continuam a manter activas nesses países permitem-lhes contar com assistência logística e emocional durante o processo de recuperação.

Contudo, nem todos os participantes que desejam fazer uso de serviços de saúde transnacionais reúnem estas condições. Dificuldades económicas ou restrições legais à saída da Holanda surgem como barreiras altamente inibitivas destas aspirações. Perante esta situação definem-se outras estratégias, entre elas, o recurso a práticas transnacionais de auto-medicação. A 'importação' de medicamentos prescritos noutros países é uma prática relativamente comum no seio daqueles que se vêm impossibilitados de se deslocarem mas, ainda assim, acreditam na melhor qualidade dos cuidados de saúde fora da Holanda. A este tipo de práticas estão associados, no entanto, riscos acrescidos de deterioração do estado de saúde, já que estes 'tratamentos' não são sujeitos a supervisão médica.

O 'bom médico'

O bom médico

A descrição das qualidades inerentes a um profissional de saúde para que este seja considerado um 'bom médico' é, em larga medida, apresentada por comparação com as qualidades observadas em profissionais de saúde noutros países. De acordo com os participantes, um 'bom médico' deve ser atento, amigável, de confiança, disponível e familiarizado com o estado de saúde do doente, mas também directivo e determinado em relação ao tipo de tratamentos mais adequados, chamando a si a liderança das consultas.

Tal como referido, a confiança assume-se como uma característica fundamental para o desenvolvimento de uma boa relação médico-doente. Para que os participantes sintam que podem confiar nos seus médicos, um determinado número de rotinas deverá ser cumprido durante a consulta médica. Os participantes esperam que o médico leve o tempo que for necessário – de modo a que o doente se sinta confortável – coloque questões que os ajudem a identificar e comunicar os seus sintomas, execute exames, faça diagnósticos correctos e, finalmente, proponha tratamentos eficientes (o que inclui o encaminhamento para outros profissionais de saúde sempre que necessário). Estas expectativas realçam a clara preferência dos participantes por uma relação médico-doente do tipo mais paternalista. Esta preferência contrasta, no entanto, com as suas experiências na Holanda, particularmente no que respeita à necessidade de negociar tratamentos, já que o sistema de saúde holandês implica a adopção de um papel activo enquanto utente/doente.

Discussão

Este estudo foi desenvolvido com o objectivo de se proceder à identificação das características que constituem um bom profissional de saúde na perspectiva dos cabo-verdianos na Holanda, procurando-se, deste modo, reunir informação e gerar maior entendimento sobre a forma como se processa o acesso destes imigrantes aos serviços de saúde no país de acolhimento. Constatou-se que uma parte dos utentes entrevistados se depara com impedimentos vários que condicionam o seu acesso ao sistema de saúde holandês. Esta situação repercute-se, na prática, na procura e uso de cuidados de saúde alternativos que, não raras vezes, se encontram além fronteiras.

A análise das barreiras que impedem o acesso aos serviços de saúde por parte dos participantes neste estudo poderá contribuir para uma melhor

compreensão sobre os factores que estão na origem da procura de cuidados transnacionais e do subuso dos serviços de saúde na Holanda. Com efeito, foram identificadas três barreiras no acesso aos cuidados de saúde, nomeadamente: falta de informação sobre os serviços de saúde disponíveis, problemas na relação com os profissionais de saúde e dificuldades em lidar com a condicionalidade da ajuda prestada. Estes problemas encontram-se profundamente interligados e estão relacionados com dois tipos de factores. Ao nível macro, estes incluem as características organizacionais e estruturais do sistema de saúde holandês. Ao nível micro, os problemas encontrados derivam do desfasamento de expectativas entre cabo-verdianos e profissionais de saúde relativamente à forma pela qual os cuidados de saúde devem ser prestados. Com o que se segue, pretende-se explorar os efeitos dos problemas relacionados com desenvolvimentos ao nível macro.

Nas duas últimas décadas, os sistemas de saúde ocidentais têm sido confrontados com uma tendência crescente para a implementação de *managed care*, com o objectivo primordial de maximizar a sua eficiência (Anthony, 2003). Este tipo de abordagem implica a reorganização radical dos serviços de saúde levando ao aumento significativo das unidades organizacionais. Adicionalmente, incentiva-se a racionalização, a estandardização e a monitorização dos diagnósticos e dos tratamentos (Ingleby, 2005). Na Holanda, este processo tem vindo a caracterizar-se por uma transferência de poder do Estado para as agências seguradoras que não só financiam a prestação e o uso de serviços de saúde como também desempenham um papel chave na gestão desses mesmos serviços (veja-se o capítulo 3). Tem-se vindo ainda a verificar uma mudança no tipo de filosofia de prestação de cuidados adoptada, que se vê agora orientada em favor da procura (*demand-oriented*) mais do que pela oferta (*supply-oriented*). Estas alterações implicam, por sua vez, uma mudança nos papéis atribuídos a utentes e a profissionais de saúde.

Os profissionais de saúde têm sido alvo de crescentes pressões para agirem como empresários, sendo compelidos pelas 'forças do mercado' a oferecer produtos de qualidade ao menor custo possível (Van der Oers, 2003). O cumprimento destas directivas assume-se particularmente difícil no caso dos médicos de família. A escassez deste tipo de profissionais na Holanda (OECD, 2000) tem conduzido a uma sobrecarga no número de pacientes atribuídos a cada médico, limitando o tempo de consulta a dez minutos por paciente. Para além disso, lado a lado com a variedade de origens, etnias e culturas presentes na Holanda, os médicos de família deparam-se nos seus consultórios com uma crescente diversificação de necessidades, modelos explanatórios e expectativas por parte dos seus doentes. As restrições im-

postas à duração das consultas e a implementação de procedimentos estandardizados de prestação de cuidados poderão estar a condicionar a disponibilidade dos médicos de família para estimularem uma relação médico-doente capaz de levar em conta a diversidade da população que lhes compete servir. Este estudo não permite a reflexão sobre as perspectivas dos profissionais de saúde neste assunto – o que constitui uma das suas limitações.

Como foi referido anteriormente, a implementação de princípios de *managed care* tem conduzido igualmente a alterações no papel reservado aos utentes dos serviços de saúde. Com efeito, é esperado que estes actuem como consumidores criando a 'procura' para diferentes tipos de serviços e seleccionando os serviços que melhor servem as suas necessidades. Estes desenvolvimentos, requerem a 'proto-profissionalização' dos utentes, isto é, a adopção de atitudes e de conceitos básicos empregues habitualmente nos círculos profissionais, de modo a poderem solicitar cuidados de saúde de uma forma pragmática e eficaz (De Swaan, 1990) que, entre outras coisas, compreende a capacidade de negociação. Para além disso, implicam ainda que a relação médico-doente estabelecida assente, ao invés da hierarquia, na simetria de papeis conferidos a cada um dos intervenientes. Neste contexto, acresce ainda a necessidade de formação de organizações capazes de defender os interesses dos utentes, através do lobby para a criação de cuidados de saúde talhados à medida das suas necessidades (*tailor-made care*).

Os imigrantes na Holanda encontram-se sub-representados em organizações de utentes (De Graaf e Eitjes, 2004; Van Dijk, 2003) e insuficientemente 'proto-profissionalizados', especialmente no que concerne à saúde mental (Kortman, 2003). Esta situação aplica-se também ao caso dos cabo-verdianos assumindo-se particularmente problemática com respeito aos serviços de saúde mental. A doença mental continua a ser altamente estigmatizada no seio da comunidade cabo-verdiana, verificando-se, frequentemente, o isolamento das pessoas que vivem este tipo de problemas, perante o medo de vitimização e de intriga. Estas circunstâncias impedem claramente a 'proto-profissionalização' dos círculos por onde os cabo-verdianos se movimentam. Consequentemente, a aquisição das competências necessárias à negociação de cuidados vê-se comprometida, conduzindo à criação de assimetrias na relação médico-doente e a subsequentes limitações no acesso aos serviços de saúde especializados.

Até agora, abordou-se a forma pela qual as características inerentes ao sistema de saúde holandês poderão estar a funcionar como factores de repulsão (push) compelindo os cabo-verdianos a percepcionarem a necessidade de recorrer a

serviços de saúde transnacionais. Assume-se ainda como relevante a reflexão sobre o tipo de factores de atracção (*pull*) encontrados em sistemas noutros países que garantem a percepção da melhor qualidade desses serviços.

Dada a escassez de estudos comparativos sobre sistemas de saúde, é difícil apontar com exactidão quais as características inerentes a outros sistemas europeus que facilitam o acesso dos cabo-verdianos aos cuidados de saúde. É sabido, contudo, que a prestação de cuidados de saúde difere consideravelmente nos países desenvolvidos. Payer (1989) mostra como a cultura nacional e as filosofias inerentes à prestação de serviços de saúde influenciam práticas distintas de medicina em países como a França, Inglaterra, Alemanha e Estados Unidos, enfatizando que a escolha e a aceitação de certos diagnósticos e tratamentos são culturalmente determinadas ao invés de serem cientificamente definidas.

Como se evidencia no capítulo 3, a prática da medicina na Holanda segue predominantemente uma filosofia de prevenção. Directivas recentes advertem para a adopção de uma atitude de *watchful waiting* (NGH e LHV, 2002) antes de se dar início a qualquer tipo de intervenção. Este tipo de prática traduz-se, muitas vezes, no que é descrito no capítulo 4 como 'tratamento Paracetamol', criando frustrações quer por parte das comunidades imigrantes quer entre os nacionais holandeses.

Este tipo de tratamento traz também profundo descontentamento e frustração aos participantes neste estudo. Com efeito, na perspectiva dos participantes, a prescrição de 'uma simples receita de Paracetamol' coloca em causa a autenticidade dos problemas de saúde sentidos e comunicados, assim como a sua integridade enquanto doentes. De acordo com as experiências e expectativas dos participantes, o tratamento adequado dos seus problemas de saúde implica o emprego de certos procedimentos médicos, nomeadamente: a execução de exames físicos, a prescrição de medicamentos específicos para o problema detectado e, finalmente, o encaminhamento, sempre que necessário, para profissionais especializados. Ora, estes procedimentos presumem-se como sendo mais característicos na prestação de serviços de saúde em Portugal e França. Contudo, também em Portugal se assiste, hoje em dia, a uma certa mudança na prática de medicina, sendo a execução de exames físicos uma prática menos corrente do que no passado.

A maior diferença entre os sistemas de saúde português e francês por comparação com o sistema holandês parece residir, no entanto, no grau de dependência dos médicos de família no que concerne o acesso a cuidados de

saúde especializados. À semelhança da Holanda, o encaminhamento para especialistas em Portugal é também dependente da consulta prévia com estes profissionais. Efectivamente, nos últimos anos, têm sido feitos inúmeros esforços no sentido da promoção da função de *gatekeeping* atribuída ao médico de família. Contudo, na prática, uma percentagem significativa de pessoas procura directamente os serviços de urgência dos hospitais, sendo encaminhado para especialistas sempre que necessário (Bentes *et al.*, 2004). Por sua vez, na França, o uso de serviços especializados pode ser efectuado mediante a vontade de cada doente, sem que se verifique qualquer necessidade de informar o médico de família e obter o seu consentimento (Sandier *et al.*, 2004). Dadas estas circunstâncias, o impacto de possíveis problemas ao nível dos cuidados de saúde primários é muito diferente entre estes países. Ao passo que na Holanda uma boa relação com o médico de família surge como condição fundamental para o acesso a qualquer outro tipo de cuidados, em Portugal e na França um bom relacionamento com os médicos de família poderá contribuir para que esse acesso seja facilitado – mas não é condição necessária para a sua ocorrência.

A Holanda tem vindo a adoptar uma atitude radicalmente diferente da atitude de adoptada por Portugal e pela França relativamente às políticas de saúde para as populações imigrantes. Com efeito, têm sido implementadas várias reformas com o objectivo de promover serviços de saúde 'culturalmente-sensíveis' e orientados para as necessidades específicas das populações imigrantes. Estas reformas determinaram até ao momento, a criação de serviços específicos para imigrantes, o desenvolvimento de um centro nacional de conhecimento e a incorporação de mediadores culturais em vários dos serviços existentes. Este processo recebe a designação de 'interculturalização'. A França, pelo contrário, tende a adoptar uma atitude passiva, reflectindo uma ideologia mais 'assimilacionista' que enfatiza a adaptação dos migrantes aos serviços disponíveis (Bollini, 1992).

Já em Portugal, tem-se vindo a notar um maior interesse e consciencialização para as necessidades de cuidados de saúde dos imigrantes mas não foram, até ao momento, implementadas quaisquer políticas de saúde multiculturais ou programas específicos para migrantes a nível nacional[3] (De Freitas, 2003). As diferenças sentidas entre estes três países poderiam conduzir-nos a pensar que a Holanda, enquanto país pioneiro na implementa-

3. Foi recentemente (em 2004) implementado o primeiro serviço de saúde mental transcultural – Consulta do Migrante – em Lisboa, no Hospital Miguel Bombarda. Este serviço conta com a presença de vários tipos de profissionais, incluindo psiquiatras, psicólogos, enfermeiros e um antropólogo, e está disponível um dia por semana.

ção de políticas multiculturais de saúde, tenderia a oferecer melhores condições de acesso a serviços de saúde de boa qualidade para os participantes neste estudo. Estas expectativas contrastam, no entanto, significativamente com as experiências descritas pelos cabo-verdianos. Os cabo-verdianos parecem ter uma ideia bem fundamentada do tipo de cuidados que melhor se adequam às suas necessidades. De facto, o tipo de características que identificam como necessárias a um 'bom médico' assemelham-se, em larga medida, às características apontadas por profissionais de saúde na Grã-Bretanha (veja-se o capítulo 3). No entanto, apesar destas competências, o encontro com o 'bom médico' nem sempre se mostra prontamente possível na Holanda. Aqui, parecem estar presentes os factores que, ao nível micro, condicionam o acesso aos cuidados de saúde. Verifica-se, com efeito, um desfasamento de expectativas entre os utentes cabo-verdianos e os profissionais de saúde na Holanda relativas a vários elementos intrínsecos à prestação de cuidados de saúde. Entre estes, encontram-se o tipo de relação médico-doente a ser estabelecida – e, dentro deste domínio, os papéis atribuídos a cada um dos intervenientes – o tipo de rotinas médicas a serem executadas e o tipo de tratamento a ser prestado.

Efectivamente, a maioria dos participantes deparou-se com uma abordagem à prestação de cuidados que lhes é pouco familiar e com a qual nem sempre se sentem confortáveis. A expectativa de que os profissionais de saúde tenderiam a assumir um papel mais paternalista na relação médico-doente não é corroborada. Ao passo que os cabo-verdianos esperam receber conforto, apoio e conselhos por parte dos profissionais de saúde – atribuindo-lhes um papel directivo no processo de recuperação, justificado pela sua perícia na área da saúde – os mesmos profissionais tendem a estimular uma relação pautada pela mutualidade, promovendo uma parceria com os seus clientes, em igualdade de circunstâncias, de modo a encontrar conjuntamente uma solução para os problemas apresentados. Face à expectativa de que os cuidados de saúde devem ser sempre prestados imediata e incondicionalmente, é com bastante estranheza que os cabo-verdianos se dão conta da necessidade de negociar a ajuda prestada, através da adopção de um papel activo na solicitação de cuidados. Na perspectiva dos cabo-verdianos, este tipo de relação tende a ser visto como uma relação de negócios.

Na Holanda, é prática pouco frequente entre os médicos de família examinar os seus clientes durante a consulta sem que estes façam expressamente um pedido neste sentido. Este tipo de rotina é altamente valorizado pelos cabo-verdianos entrevistados, sendo percepcionado como um indicador do interesse por parte profissionais de saúde pelo cliente. A não consubstan-

ciação destas expectativas tende a exercer um impacto negativo sob as percepções de alguns participantes com respeito aos profissionais de saúde na Holanda, levando-os a definir o 'bom médico' por oposição aos profissionais com quem contactam.

Isto não significa, no entanto, que a possibilidade de encontro e contacto com 'bons médicos' se veja completamente excluída. Efectivamente, uma parte dos participantes manifestou satisfação com os cuidados que lhes foram prestados. Esta situação aparece, porém, condicionada pela capacidade destes adaptarem a forma pela qual procuram ajuda ao modelo prevalecente na Holanda, isto é, de agirem como 'bons doentes' (veja-se o capítulo 3). Por outras palavras, o benefício de serviços de saúde de qualidade surge associado à aptidão dos participantes de incorporarem o papel de utentes emancipados, ou seja, de utentes que tomam a si a iniciativa de apresentar os problemas que os afligem, de forma clara e pragmática, e que solicitam assertivamente a prestação de cuidados. A adopção deste tipo de atitude envolve ainda a participação activa na decisão relativa ao tratamento. Como observado, este tipo de comportamento contrasta consideravelmente com as expectativas dos cabo-verdianos exigindo uma profunda reconceptualização do que significa ser e agir como utente/doente.

Ainda que vários participantes tenham sido capazes de se adaptarem ao sistema de saúde holandês outros há, porém, que sentem sérias dificuldades em o fazer. Nestes casos, os tratamentos recebidos são percepcionados como inadequados, emergindo sentimentos de rejeição, vulnerabilidade e descrédito. Ao mesmo tempo, os profissionais de saúde são vistos como negligentes e indignos de confiança. Este tipo de sentimentos minam claramente o estabelecimento de uma boa relação com os profissionais de saúde, levando, por vezes, a situações de total descontentamento e, consequentemente, ao *dropout*. Muito embora, as dificuldades com o domínio do idioma neerlandês tenham aqui um papel relevante, dificultando a comunicação, o curto tempo reservado às consultas com os médicos de família assume-se como o factor verdadeiramente preponderante no exacerbar destes desentendimentos, já que impossibilita a satisfação de expectativas de parte a parte. A prescrição de Paracetamol emerge, neste contexto, como o exponente dos cuidados de saúde inadequados. Os participantes que se encontram nesta situação não deixam, no entanto, de procurar a ajuda que consideram apropriada. Enquanto tentam obter acesso aos serviços de saúde holandeses, procurando dar conta das suas complexidades, exploram igualmente os cuidados disponibilizados por outros sistemas de saúde, como uma estratégia complementar. A presença de redes transna-

cionais de apoio fortes, a maximização de recursos identificados durante experiências migratórias anteriores e uma certa idealização da qualidade dos profissionais de saúde fora da Holanda são factores preponderantes no incentivo ao uso de serviços de saúde de outros países.

Muito embora os cuidados de saúde na Holanda pareçam estar a desenvolver-se no sentido de responder às necessidades da população autóctone, a satisfação das populações imigrantes parece, contudo, estar a ser deixada para trás. Esta constatação parece fazer sentido no caso dos imigrantes cabo-verdianos cujo uso dos serviços de saúde disponíveis tende a ser menor do que seria de esperar face aos problemas que apresentam. O subuso dos serviços de saúde na Holanda por parte dos cabo-verdianos poderá ser explicado pelas dificuldades sentidas no acesso aos serviços de saúde holandeses bem como pelas estratégias transnacionais empregues com o objectivo de aceder a serviços de saúde de boa qualidade. Em particular, detecta-se que o subuso dos serviços de saúde não é justificado pelo facto desses imigrantes definirem poucos esforços na procura de cuidados de saúde formais. Na realidade, o acesso à saúde é extremamente valorizado pelos cabo-verdianos, que não poupam quaisquer esforços para o alcançar. Tomando aqui as palavras de um dos participantes: 'a saúde não tem fronteiras'.

PART II. ORIGINAL MANUSCRIPT

Seeking the good doctor - When 'Health knows no Borders'

Introduction

A shift from 'monocultural' to multicultural social policies in Western countries has led to increasing concern regarding the provision of culturally sensitive health care. This is a logical consequence of the notion of equal rights and citizenship for members of all ethnic groups. Critics argue that it is not enough to ensure that all groups are offered the same care, because identical care for minorities might actually mean inadequate care. The services delivered must make sense to its recipients. They must take into account the way by which problems are experienced, how they are communicated and how beliefs about those problems impact on expectations regarding treatments.

In the Netherlands an ongoing discussion concerning the effectiveness and accessibility of health care has been present for decades. This discussion involves not only politicians and policy-makers but also the public opinion, social scientists, health professionals and, to an increasing degree, users themselves.

It appears that health care is not accessible in the same way for all ethnic groups in the Netherlands (Knipscheer, 2000; Van Dijk and Van Dongen, 2000). Despite the scarce number of evidence-based studies, social scientists generally agree that migrant service users tend to experience poorer access to care. At the same time, migrants are often labelled as risk groups and considered problematic users. Why is it so? Research shows that migrants' experiences of health, explanatory models and the help-seeking process are frequently unfamiliar to care providers and often collide against their expectations. These differences tend to hinder the provision of good quality care, limiting its accessibility and contributing for an increased probability of risk and subsequent health and socio-economic problems (Van Dijk and Van Dongen, 2000). Moreover, although a demand-oriented care philosophy still prevails today the last developments in Dutch health care policy have accentuated the responsibilities of users in making care appropriate to their needs. But how can users with limited access to health care contribute to make that care more in balance with their needs?

This is clearly a difficult task. It may nevertheless be accomplished if (potential) users find support in achieving it. The space awarded for the voicing of

users' needs and opinions regarding health care needs to be amplified. Users have a chief role in providing clues for making care suited to their needs. Yet, the promotion of demand-oriented care is a complex process which requires multi-level participation. Co-operation between policy-makers, health professionals, and advocacy and empowerment organisations for clients, users and social scientists needs to be further stimulated. Research studies constitute a possible way for raising awareness on users' perspectives and they might be used as a catalyser for multi-party communication. Additionally, research might play an important role in demystifying stigmatising opinions that label migrants as risk groups.

This study attempts to bring some insight on the question regarding migrant users' health care needs and its relation with the use of (mental) health care services by focusing on the case of Cape Verdean immigrants in the Netherlands. Despite the considerable number of countries who host the Cape Verdean diaspora few international data on Cape Verdeans' experiences of health and health care use exist. It is known however that a part of the Cape Verdean population in the Netherlands experience psychosocial problems and show a lower self-perceived health status when compared to the autochthonous population. Cape Verdeans have also been noted to under-use mental health care, i.e. although the need for care appears to exist they make few use of the services available. How must the under-use of health care be understood in regard to Cape Verdean immigrants in the Netherlands? This is a multifaceted question, which can be approached from different angles.

Several possible factors might explain Cape Verdean immigrants' under-use of mental health care: as part of a tightly-knit community which relies on solidarity and a strong social network, Cape Verdeans may not experience the need to take their problems outside the community, or might even feel pressure not to do so; moreover, Cape Verdeans might benefit from their own circuit of healers and providers (Beijers, 2004). The strongly paved Cape Verdean transnational ties (Meintel, 2002) might play an important role in this process; on the other hand, it is possible that Cape Verdeans lack access to mental health care which they identify as appropriate to their needs.

In this piece, an attempt is made to analyse Cape Verdeans' access to care and the way by which it might influence their use of (mental) health care services. One way to make this task feasible is to inquire about Cape Verdeans' expectations of and experiences with health care professionals. The ultimate goal of this study lies in identifying what Cape Verdeans consider to

be a 'good doctor'. This category can be used to evaluate the characteristics and qualities necessary to a health professional in order to provide for and facilitate the access to good quality health care.

In the Netherlands, primary care is provided to a large extent by general practitioners (GPs). These professionals hold a key-function as gatekeepers to the health care system. Contact with medical specialists and public sector mental health professionals is possible only through referral of the general practitioner. GPs have thus an essential role in creating the necessary conditions for users to access care. Given this situation, this study focus not only on Cape Verdeans' perceptions of what a good mental health professional is but also on what a good general practitioner should be like. The concept 'good doctor' is used here as a category that includes both general practitioners and mental health providers who are described by users as good professionals. This study attempts to answer the question: what do Cape Verdeans consider to be a good doctor? As well as the following sub-questions:

1. Have the informants come across a good doctor in the Netherlands? What features characterised the doctor?
2. Do the informants actively seek for the good doctor? How is that process carried out?
3. Have the perceptions of the informants concerning good doctors been influenced by experiences with the Dutch health care system? In what way?
4. Do the informants identify differences between health care professionals in the Netherlands and in Cape Verde, or any other country?
5. Do the informants resort to alternative help-seeking?
6. How do informants handle conflict with doctors?
7. According to the informants, what sort of steps must a doctor follow to become a good doctor?

Goals and methodology

This study aims at gaining in depth knowledge of Cape Verdean immigrants' perceptions concerning what a good doctor is in the Netherlands. There are two sub-goals. The first concerns the documentation of Cape Verdeans' expectations regarding the performance of health professionals. The second consists of bringing insight on the possible factors leading to Cape Verdeans under-use of care in the Netherlands, with particular attention to the issue of access to care.

Given the exploratory nature of this study and its focus on users' views the use of qualitative methods appeared most appropriate. This study began by a review of the available literature concerning Cape Verdeans' migration process, with particular focus on migration to the Netherlands. As a means to provide a contextual view of the population health status and health care use in the Netherlands a revision of the literature was carried out and later contrasted with the data available for the Cape Verdean population. As the study progressed it became evident that the philosophies prevalent within the Dutch health care system are a relevant issue when attempting to gain insight on Cape Verdeans' perceptions of health care professionals. Literature on this issue was scarce. For this reason I resorted to an interview with Martijn Kole, a member of a client support organization – Cliëntenraad Utrecht. I also gathered information through informal talks with social scientists.

Fieldwork took place in the city of Rotterdam where most Cape Verdeans in the Netherlands live between October and December 2003. Face-to-face in-depth interviews were employed to collect data about participants' migration history, previous experiences with health care professionals and health care systems, perceptions and expectations of health care providers in the Netherlands, perceived needs for alternative care and strategies used to seek for appropriate health care.

Epidemiological data concerning Cape Verdeans' state of (mental) health is scarce. For this reason, five key-informants were contacted and interviewed as a means of testing the interview guide and collecting data on Cape Verdeans' pathways to health. All key-informants were social workers at associations and organisations which have specific projects designed to attend the needs of the Cape Verdean community. Participants were contacted in a second phase of the study through the help of some of the key-informants and through snow-ball referrals. Due to the seriousness of the health problems experienced, particularly in the cases of mental distress, some of the Cape Verdeans who initially showed interest in participating on the study later felt compelled to decline the invitation. Their choices were respected with no further inquiries. These situations reflect the difficulties of recruiting informants experiencing mental distress.

In total, seven immigrants of the Cape Verdean community in the Netherlands were interviewed. The purpose of the study was explained prior to the interviews and all participants were assured with the confidentiality of their statements. The latter aspect proved of extreme relevance, and in some instances of a certain relief. As both participants and key-informants explained,

mental illness remains stigmatised among the Cape Verdean community and many people do not seek help out of fear of exclusion. Verbal consent for participation on the study was obtained before the beginning of each interview. The interviews were conducted in Portuguese using a semi-structured interview format with open-end questions. The interview guide is presented in appendix A. All participants were fluent in Portuguese. Only when expressions unknown to the researcher were employed was clarification necessary. This was at all times carried out promptly with ready collaboration from the participants. All interviews were audio taped with the permission of the participants and later transcribed verbatim and translated to English. The interviews were held at the locations and times suggested by the participants, lasting between one and two hours. Six of the interviews were conducted at the participants' homes. The one remaining took place at the participant's working facility.

The data was analysed with basis on an editing analysis approach. Drawing on this type of analysis the researcher first 'opens up' the data by applying descriptive codes and then develops and revises categorical codes as patterns identified in the data (Miller and Crabtree, 1999). Several themes were identified. These themes are illustrated by the English translation of direct quotes from the interview data. The names aggregated with the quotes cited are pseudonyms. Quotes are presented in smaller type. Several themes appeared recurrently: the relationship with general practitioners and mental health professionals, unconditional help, referrals, the good doctor and transnational health resources and practices. These themes are described in chapter four organised according to four topics: expectations concerning the performance of health care professionals, perceptions concerning the performance of health care professionals, transnational health care seeking and the 'good doctor'. Finally, the features pointed out by participants as necessary to characterize a good health professional were confronted with the list of 'key qualities' that identify a 'good doctor' as presented in chapter three.

The participants

Seven immigrants of the Cape Verdean community in the Netherlands composed the sample of the study. The participants consisted of six women and one man who ranged in age from 33 to 58 years. The mean age was 46,4. The average time of residency in the Netherlands was 15,4 years, varying between 2 and 33 years. All participants lived in the region of Rotterdam. Age upon arrival to the Netherlands ranged from 7 to 45 years (mean at 31). All participants were employed at some point in time during their permanence in the Netherlands. Of these, four did not work at the time of the interviews

and were under a social welfare scheme due to health problems. Jobs carried out previously were mostly low qualified (e.g. factory work, housecleaning, hospital maintenance work). Among the remaining three was a social worker, a factory worker and a retired seaman. Education levels varied from low to medium and only one participant had a college degree. Four of the participants were divorced, two were single and one was married. All participants stated their affiliation with the Catholic religion but most did not visit the Church on a regular basis.

The demographic profile of the participants resembles, in part, the characteristics of the general Cape Verdean migrant population in the Netherlands. Exceptions are the variables age, gender and employment status. The Cape Verdean community is to a great extent composed of young people (67% is younger than 35 years) (ISEO/COS, 2001). Although the number of first generation Cape Verdean women is higher than men the difference is not significant (Ministerie van Justitie, 2004). Up to 70% of the Cape Verdeans hold a paid job. This is a significantly high percentage if compared to that of Dutch natives employed (43%) (Bol, 1998) but Cape Verdeans tend to occupy low-qualified and poorly paid jobs. The small number of participants actively employed may be understood in virtue of the specific conditions of the population this study targets for, i.e. people who experience or have experienced (mental) health problems.

All participants are first generation immigrants. Three of the participants were not born in Cape Verde: two have Angolan ancestry and were born in Portugal and one was born in Saint Tome and Principe. This was not known to the researcher until half-way the interviews. According to the participants, place of birth was not a determinant feature regarding their affiliation with the Cape Verdean community. Ever since their arrival to the Netherlands they relate to Cape Verdeans, participate in Cape Verdean organised activities and celebrations and resort to the Cape Verdean community when in need of support. They experienced no difficulties in finding their way into the community because they share Portuguese as a common language and a similar historical colonial background. Additionally, both institutions and social support projects designed to attend the needs of Cape Verdeans in the Netherlands often provide services and promote initiatives where immigrants of other countries who share the same language, interests and needs are welcome. These services and initiatives thus work as a platform to built and uphold social relationships within the Cape Verdean community. Drawing upon Gilroy's definition of community as '... a particular set of values and norms in everyday life: mutuality, co-operation, identification and sym-

biosis' (1987: 234) and on participants' identification and involvement with the Cape Verdean community no reasons were found to exclude them from the study sample.

Participants' migration histories and health care use

The migration histories of the participants are diversified and encompass the characteristics of the different immigration waves of Cape Verdeans to the Netherlands. Three phases of immigration can be identified which relate directly to shifts on immigration policy at the host country and political changes in the motherland. The first Cape Verdeans to settle in the Netherlands were seamen employed at commercial ships who later found jobs ashore the Rotterdam area. Soon after settlement they began to sponsor other newcomers', initially by funding their voyage and helping them finding jobs and accommodation and later on through family reunification and family formation (Gemeentarchief et al., 2002). The first phase of migration took place between the 1950s and Cape Verde's independence in 1975. Most people arriving during this period were labour migrants, and somewhat later their families, who expected to return to the islands once enough earnings were gathered. Two participants arrived during this period. One was as a seaman at a Dutch company. The other participant was brought along by her parents still a young girl. Both these participants acquired Dutch nationality.

With the independence of Cape Verde labour migration became substantially more difficult. The second phase of migration ran from off that period until the early 1990s and it was marked by a shift from low to high qualified migrants and, especially, from labour migration to family reunification. Two participants migrated during this time. The first came as a labour migrant. This became possible by opting for Portuguese nationality at the time of independence. As she migrated to the Netherlands before Portugal entered the European Economic Community in 1986, she adopted the Dutch nationality to guarantee entitlement to a permanent stay. The other participant shared a similar background and came to the Netherlands to reunite with her husband. She arrived after 1986 which allowed her to keep Portuguese nationality.

The third phase of migration began after 1991 when the first multi-party elections were held in Cape Verde. Highly-educated people as well as students pursing education abroad constituted the main bulk of migration. There was also a strong female component to these migration flows. Many women moved first to other European countries working mostly as domestic workers

while awaiting an opportunity to migrate to the Netherlands. Immigration laws began to tighten during this time and many found their way in through marriage. Stricter immigration policy has followed since the mid-1990s. Marriage to Dutch citizens no longer promptly entitles the foreign spouse to permanent residence and since 2002 applications to marry non-EU citizens must be filed from their country of origin. Three of the participants arrived during this last phase. Two of them had been working for a number of years in France and held a Portuguese passport which facilitated their entry in the Netherlands. The third migrated in the early-1990s through marriage to a Cape Verdean man naturalised Dutch.

Four of the participants lived in other host countries before settling in the Netherlands. Among these, three lived in two or more host countries. Previous countries of migration include Portugal, Spain, France, Italy, Guinea-Bissau and the United States. All participants consulted with health care providers at least once before they settled in the Netherlands: two had contact with psychologists; three contacted with medical specialists; and they all contacted with general practitioners (GPs). At the time of the interviews, three of the participants were still consulting with health professionals in previous migration countries within Europe whenever they had the chance to. One of those participants was periodically examined by a specialist doctor in France. The use of health care in previous migration countries was facilitated by the perpetuation of health insurances held at the time participants lived and worked in those countries.

All participants were entitled to health care in the Netherlands through a national health insurance regime. Four of the participants did not hold an active professional occupation due to health problems: two participants had chronic illnesses (Lupus and Sickle cell anaemia) of which one was diagnosed with depression; one participant suffered from breast cancer in the past and had depression; and one participant experienced mental distress but her condition was not clear to the researcher. Another participant expressed psychological unrest but she had not yet consulted a professional and was actively employed. The two remaining participants benefited of good health. All participants consulted with the GP at least once in the Netherlands. In total, five participants contacted with specialists and four with mental health providers. At the time of the interviews, two participants visited medical specialists periodically and three had contact with mental health professionals (two with psychiatrists and one with a psychologist). One participant awaited a first session with a psychologist.

Structure of the thesis

This thesis is divided in five chapters. The first chapter provides an account of Cape Verdeans immigrants, their history and their position in Dutch society. Special attention is put into the Cape Verdean long-term history of migration. The second chapter describes migrants' health status in the Netherlands and the issues concerning access to health care, and in particular mental health care. It also attempts to bring some insight on the situation of Cape Verdean immigrants in that context. The third chapter turns attention towards the interaction between doctors and patients and the notion of 'good doctor'. An account on the philosophies within the health care system is provided and followed by considerations on the 'good' and 'bad' patients. These three chapters constitute a means of providing the context where the participants of this study experience health and illness, seek for help and initiate contact with health professionals. The forth chapter provides the research results. Finally, the last chapter brings about a discussion of the findings and recommendations for good practice.

1

CAPE VERDE: WITHIN THE SHORES OF THE ATLANTIC

Migration is a deeply rooted phenomenon in Cape Verdean society dating back to the early colonial period. Its vast history and multiple facets make it a relevant study case within international migration and a strong source for theoretical reflection. The features characterizing Cape Verdean immigration are of substantial importance in understanding the relation between immigrant communities and receiving societies. The problems encountered in the latter, as well as the coping strategies deriving from the challenges posed by integration, must be seen in light of a broader context which includes the migration process itself, identity issues and social recognition.

This chapter begins by providing a general account of the history, geography and society of Cape Verde. Secondly, a description of the migration phenomenon is provided including both *de facto* movements and the aspirational component of those movements. A theoretical account of Cape Verdean immigration follows with particular attention for its transnational aspect. Lastly, focus is put on Cape Verdean immigration to the Netherlands and to the way issues of identity and social recognition take form in that country.

1.1 History, geography and society

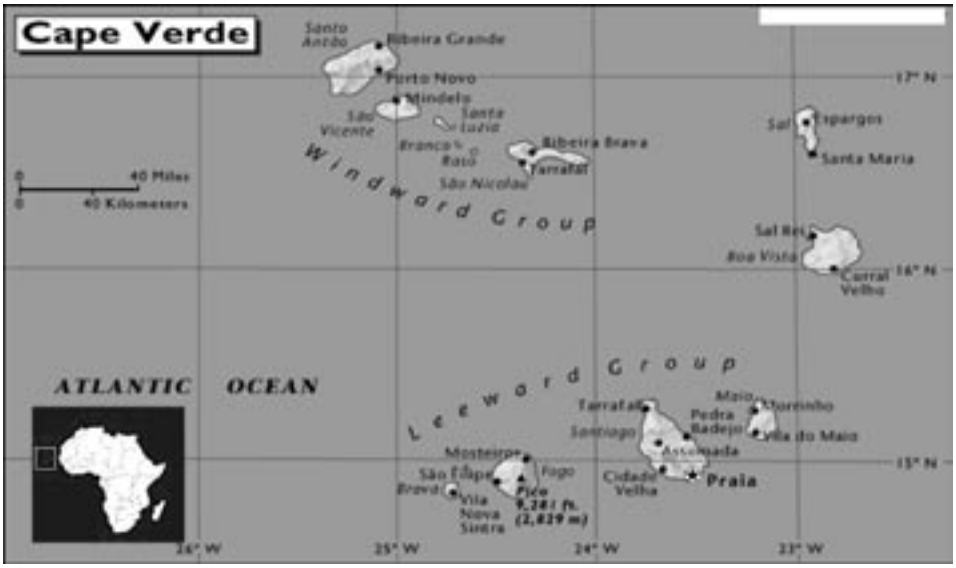
> "On the 16th of January, 1832, we anchored at Porto Praya, in St Jago, the chief island of the Cape Verde archipelago. The neighbourhood of Porto Praya, viewed from the sea, wear a desolate aspect. The volcanic fires of a past age, and the scorching heat of a tropical sun, have in most places rendered the soil unfit for vegetation. The country rises in successive steps of tableland, interspersed with some truncate conical hills, and the horizon is bounded by irregular chain of more lofty mountains. (...) The island would generally be considered as very uninteresting; but to anyone accustomed only to an English landscape, the novel aspect of an utterly sterile land possesses a grandeur which more vegetation might spoil".
>
> (Charles Darwin, 1845)

Cape Verde was uninhabited at the time of its discovery in 1460 by navigators at the service of the Portuguese Crown. Historians debate however that other African peoples might have known the islands at the time. Soon after discovery, the Portuguese claimed the islands as part of the Empire (Car-

reira, 1982). Santiago was the first island to be populated and nowadays it hosts Cape Verde's capital city, Praia.

The archipelago of Cape Verde is constituted by a set of ten islands[4] and several scattered islets situated 452 km to 717 km off the west coast of Africa, in a latitude close to that of Senegal. Its population has been ethnically diverse since early times. Among the first settlers were Europeans of Portuguese, Genoese, Castilian and Spanish origin and an estimated twenty-seven different West African groups, with a clear predominance of the latter. Later arrived French and English traders, as well as pirates and other seamen who married locals and settled on the islands (Meintel, 1984a). Today's population amounts to about 418,000 people (estimate by Countries of the World, 2005) and provides us with a vivid account of the extensive mixture that took place between Africans and Europeans (Meintel, 2002).

Map. Cape Verde



Source: Mapquest.com (2003)

For over five hundred years the inhabitants of Cape Verde lived under Portuguese colonial rule. Sovereignty was achieved in 1975. The independence process was much a consequence of the war for liberation disputed in

4. Nine of these islands are inhabited. They are divided in two groups: the Barlavento (winward) Islands comprising Boa Vista, Sal, São Nicolau, São Vicente Santo Antão and Santa Luzia (uninhabited); and, the Sotavento (leeward) Islands which include Maio, Santiago, Fogo and Brava (Meintel, 1984).

another former Portuguese colony, Guinea Bissau. The Partido Africano da Independência da Guiné e Cabo Verde (African Party for the Independence of Guinea and Cape Verde, PAIGC) headed this struggle on behalf of the two colonies and no armed conflicts took place in Cape Verde. Once independence was gained the members of PAIGC took leadership over Cape Verde promoting a single-party system. It was not until 1991 that the first multi-party elections were held. By then, the Movimento Para a Democracia (Movement For Democracy, MPD) was elected remaining in power for ten years. Cape Verde is currently governed by the same party following independence . The party is now called Partido Africano da Independência de Cabo Verde (African Party of Independence of Cape Verde, PAICV) (Almeida, 1997a; Leary, 1997).

Cape Verde has experienced considerable economic problems over the years. These problems are to a great extent a consequence of a long history of colonial domination. The initial goal of the colonisers was to transform the islands into a lucrative agricultural area at the service of the Empire (Halter, 1993). But, as described by Charles Darwin in the quote above, the land soon proved sterile as a consequence of the arid climate. Although the author romanticizes about the beauty and interest of such an inhospitable dry land, those characteristics and its consequences became one of the factors motivating intensive immigration in the years to come.

Cape Verde's unproductive soil and its geographically favoured position soon led the Portuguese into converting the islands on a route of interest from where ships took-off to the Gulf of Guinea, Angola, Saint Tome and Brazil. They also became a base for protecting, provisioning and careening ships, and for bringing together slaves imported from Guinea for acclimatisation and export. Cape Verde thus became a major point of connection and trade between the Old and the New World (Carreira, 1982). At the same time, the islands were made a penal colony where *degredados*, criminals and political 'undesirables' from the metropolis, were sent to. Although in a significant number of cases the penalties amounted to a few years, many remained permanently and went on to become prosperous and respectable. Mostly men exiled without their families, the *degredados* formed liaisons with slave women mingling with the rest of the population. The same is thought to have happened with the Jews that arrived escaping religious persecution in Europe. Some of the European settlers and their mulatto offspring crossed over to mainland Africa forming a middlemen class with a central role in the trade of slaves – the *lançados*. In order to solidify their social position amongst the various West African societies these men often married African women. Cape Verde had thus a dual role both as a colony and a source of intermediaries for Portugal in Africa.

The Catholic Church served as the official justification for the Portuguese slave trade - slaves brought to Cape Verde were to be converted and have their souls saved. Although Catholicism promoted distinction and social distance between slaves and owners it nevertheless fostered the 'recognition of the humanity of slaves' by encouraging legal marriages, ties of godparenthood between slaves and whites and manumission (release of slaves) (Meintel, 1984a: 78). All the way through the colonial regime Portugal fought vehemently against and forbade any religion other than Roman Catholicism. Yet, in the beginning of the twentieth century, a Cape Verdean immigrant in the United States returned bringing the Church of the Nazarene, a Protest sect. Despite unlawful and persecuted, the sect gained a significant number of followers. Together with Catholicism, it remains the most important religious practice until today (Almeida, 1997b). Meanwhile, in the 1960's another religious movement took expression. The members of this movement were known as *rebelados* (rebels) for their refusal to have contact with priests or anyone else outside their community, and for denying money and malaria prevention. The government was quick to take action over the "insurgents" arresting the movement leaders and dispersing the followers among the other islands.

Just as with Catholicism the colonisers expected and promoted the adoption of the Portuguese language in Cape Verde. Yet to the disappointment of the metropolitan observers not only did the whites born in the islands speak *Crioulo*[5] – a blend between Portuguese and West African languages, but so did newly arrived inhabitants (Meintel, 1984a). Furthermore, the insularity and lack of contact between the islands led to the development of different versions of *Crioulo* that is not always mutually understandable. *Crioulo* remains Cape Verdes' first language up to this day. Although Portuguese is the archipelago's official language, being used in formal situations such as administration and education, *Crioulo* is the way of expression Cape Verdeans are more at ease with and the language best suited for joking, storytelling, singing and sharing intimacy and feelings (Halter, 1993). Despite being used mostly for verbal expression an increasing number of poets and writers have chosen *Crioulo* to express their art. Courses and new dictionaries have been the focus of considerable attention in the past years both inside and across the Cape Verdean borders.

Draughts have always been present through the history of Cape Verde. Its consequences have had an important role both for the economic situation and the social composition of the country. Until the mid twentieth century

5. Cape Verdeans use the designation *Crioulo* to refer to their own Creole language. Officially, it is known as Kriol (Carling, 2003).

draughts caused famines and epidemics responsible for an appalling number of deaths[6]. During the years of colonisation, Portugal often neglected to provide aid in times of hunger. The metropolis also failed to implement effective reforestation policies needed to prevent the ground's erosion. The fragile ecosystem of the islands was put to further distress as the animals brought by the Europeans were left unguarded and ate the vegetation that held the soil intact after precipitation. The hardships of such conditions lead many, especially men, to migrate. In fact, when aid came it was mostly from Cape Verdean immigrants in the United States (Meintel, 1984a; Patterson, 1988).

Dependence on immigrant remittances and foreign aid takes place up to this day. At present, Portugal and the European Community are the prime bilateral and multilateral donors[7]. Cape Verde receives one of the highest levels of foreign aid in the world – 26% of its gross domestic product in 1997 (Meintel, 2002). Economic reforms are aimed at developing the private sector and attracting foreign investment to diversify the economy which relies to a great extent in tourism, commerce, transport and public services. Yet, autonomy in food production seems unlikely in the foreseeable future and unemployment reaches almost a quarter of the population (estimate by World Fact Book, 2005). Nearly two centuries after its first wave immigration is still proceeding at a steady pace.

1.2 Migration history

In the history of Cape Verdean migration two distinct types of migration can be identified: forced and voluntary migration. Presently, for all those that are able to fulfil their migratory aspirations an equal or even greater number of Cape Verdeans remain on the islands awaiting an opportunity to leave.

1.2.1 Forced migration

Cape Verde's strategic position in the Atlantic was soon noticed and exploited by the colonisers. In a short period of time the archipelago became a

6. 45,000 Cape Verdeans, almost a quarter of the population, lost their lives during two famine periods in the 1940's (1941-43 and 1947-48) (Carreira, 1982).
7. The Cape Verdean government has recently manifestated the intention of launching a formal application for membership at the European Union before the end of the year 2005. According to Cape Verde's prime minister, José Maria Neves, the connection of Cape Verde to the EU would mean "the enlargement of the security area and of stability to the south part of the Atlantic North" (in Diário de Notícias, 08/05/2005). Another less explicit goal of the government seems to be the recovery of the intermediary function Cape Verde once held within the Atlantic and lost with the end of the Cold War (in Expresso 18/04/2005).

major key-point of trade between Europe, Africa and the Americas and also an essential catalyst in the triangle of slave trafficking[8]. This constituted the start of forced migratory movements to and from Cape Verde (Carreira, 1982). These flows persisted until the mid nineteenth century when Portugal was stringently pushed by England into halting slavery.

Although the end of slavery in Cape Verde did not begin until 1856, the islands lost their key-role in the trade when the United States outlawed the trafficking in 1809. At the same time, Cape Verde went on to experience prolonged draughts and famines. This led many former slaves to become dependent and bind to their previous owners, as subsistence was not possible otherwise (Meintel, 2002). The metropolis also took advantage of the harsh living conditions in Cape Verde. The liberation of slaves in São Tomé and Príncipe, another colony of the Empire in the Gulf of Guinea, had gone in the complete opposite direction of that in Cape Verde. Once free, the former slaves of these two islands deserted leaving the cacao plantations abandoned and the harvest to rot. The extreme need for a labour force gave place to the first state-directed migration process in 1863 (Meintel, 1984a). Living and working conditions on the plantations were dreadful, often including beatings, rape and deprived diet and housing. Although it is not clear which means of persuasion were used, an estimated number of 80,000 workers, mostly from the poorer segments of society, were compelled to migrate south between 1900 and the 1960s (Carreira, 1982).

1.2.2 Voluntary migration

Estevão (2001) identifies three phases of voluntary Cape Verdean emigration. In the first phase, flows to New England were clearly predominant. Emigration to the United States is believed to have started as early as the second quarter of the eighteenth century when Cape Verdean men began to integrate the crew of American whalers that rested ashore the islands of Brava and Fogo. With the end of the American Civil War in 1865 the whaling industry experienced a dramatic loss of manpower for the textile industry on the cities. Increasing numbers of Cape Verdeans were recruited to take over those jobs as well as to fill in for the seasonal vacancies in the cranberry bogs. The stream of sojourners, travelling back and forth to the United States, kept at a steady pace reaching its peak between 1900 and 1920. In 1924 the American

8. Between 1501 and 1600 the number of slaves trafficked to the Americas via Cape Verde ranged from 650 to 800 per year. This number diminished considerably in the following century. Despite the slow down on trade 28,000 slaves passed by Cape Verde in direction to the New World during the seventeenth century (Carreira, 1972; Duncan, 1972 in Meintel, 1984a).

government implementation of a 'quota system' brought severe restrictions to immigration. Portugal allocated only a very small fraction of its quota to Cape Verde thus forcing a significant decrease of departures from the islands. In addition, the policy contributed to the accentuation of permanent settlement especially in the area of Rhode Island, as most immigrants felt obliged to stay to prevent the risk of not being able to return (Meintel, 1984b).

The second phase of Cape Verdean emigration was to a great extent the outcome of the policy in the United States, the economic crises of 1929 and the Second World War. A shift towards other destinations in South America, Africa and Europe took place but its most important feature was the severe reduction imposed on the size of the flows.

It was not until 1946 that Cape Verdean emigration regained its previous dimension. Since then a significant increase on the volume of departures took place yearly leading to a massive exodus in the end of the 1960s. Between 1946 and 1973 a total of 142,093 people left the islands. A fundamental characteristic of this third phase was its strong orientation towards Europe, in particular to Portugal, France, the Netherlands and Italy (Estevão, 2001). In the 1960s, increasing labour shortages in mainland Portugal emerged as a consequence of its own emigration to France and due to the colonial war, creating the need for the recruitment of non-qualified Cape Verdean labour (Saint-Maurice, 1997). In order to insure the satisfaction of its labour needs Portugal signed an agreement with the Netherlands in 1964 enforcing restrictive entry requirements into the latter (Meintel, 1984b). This marked the beginning of intense migration to mainland Portugal. Today the number of Cape Verdeans in Portugal reaches the 55,000, forming the biggest immigrant resident population (S.E.F., 2005). Some of the immigrants that first settled in Portugal later moved on to other European countries, especially to the Netherlands where almost 20,000 Cape Verdeans live nowadays (C.B.S., 2005).

Apart from different socio-cultural contexts each island has a rather distinct history of migration. This history is highly influenced not only by the traders that once established links with Cape Verde, but also the policies enforced at the metropolis and elsewhere and, to a great extent, by the migrants themselves. Once restrictions were imposed by the United States emigration from Brava and Fogo continued, sponsored mostly by men already settled in the receiving countries. This often happened through marriage. The spouse was then able to call for her parents. Once they were settled the entry of younger, unmarried siblings, could be facilitated (Meintel, 1984b). The same situation occurred in the case of Santiago's emigrants to Portugal. When the

economic recession hit the metropolis and labour recruitment from Cape Verde was reduced, emigrants financed their friends and family's trips (Saint Maurice, 1997; Estevão, 2001). Emigrants from São Vicente and Santo Antão to Northern Europe, especially to the Netherlands, relied first on their fellow countrymen's help to find contracts in the maritime industry. Once doors were closed to immigration in the 1990s, family reunification became mostly the only way in (Carling, 2001). The case of Italy is somewhat exceptional as women mostly dominated migration flows to that country. Furthermore, the recruitment process that took place in the 1970s was greatly influenced by Christian organizations. As the labour market was open for domestic work many sisters, daughters and mothers from Sal, Boavista and São Nicolau were sponsored to join their relatives. Up to this day, the Cape Verdean community in Italy is predominantly constituted by women (Andall, 1998).

At present, the estimated number of Cape Verdeans living outside borders surpasses 430,000 (Carling, 1997). Incidentally, there are about as many Cape Verdeans living in the archipelago as there are in the world. The following table provides a rough sketch of the distribution of Cape Verdean immigrants in the main receiving countries[9].

Table 1. Estimates of Cape Verdean Immigrants in the World

Total per Continent	**Americas.....268 300**	**Europe.....153 000**	**Africa.....93 200**
Total per Country	United States....260 00 Argentina.....5 000 Brazil.....3 000 Canada.....300	Portugal.....80 000 France.....25 000 Netherlands....18 000 Spain.....12 000 Italy.....10 000 Luxembourg.....3 000 Switzerland.....2 400 Germany.....800 Belgium.....800 Sweden.....700 Norway.....300	Angola.....45 000 Senegal.....25 000 S.Tomé & Príncipe...20 000

Source: Instituto de Apoio ao Imigrante (1998) in Carling (2001).

9. Exact figures of Cape Verdean immigrants in each receiving country are difficult to find. Furthermore, statistical criteria concerning immigrants vary from country to country. Here I use the estimates proposed by Carling (2001). The differences found between the number of Cape Verdeans living in Portugal as suggested in the text and the number proposed in these estimates might be explained by the fact that the first does not include undocumented migrants.

1.2.3 Inability to move vs aspirations to migrate

Immigration policy in Northwestern EU countries has become ever more restrictive since the 1970s. This tendency has progressively forced a halt in labour migration. Nowadays, family reunification, family formation and asylum seeking are the only lawful paths of access to those countries. These are highly bureaucratic and often prohibitive processes and its enforcement has contributed to substantial decrease of permitted entries (Muus, 2001). However, aspirations to migrate within developing countries have not weakened. For some undocumented migration became a 'back door' to the wealthy north. Still, a great number of people remain involuntarily in their home countries awaiting an opportunity to leave. This condition has been termed by Carling (2001) as *involuntary non-migration* and finds significant expression in Cape Verde.

Cape Verdean migration has been characterized by a great deal of connections between those abroad and those in the archipelago since its early times. Ties of kinship, shared values and sentiments motivated much of this contact, as did commerce. Nowadays, Cape Verdean transnationalism is also occurring at other levels. It not only includes remittances of emigrants, investments in the tourism sector and the intensification of contacts with other emigrant communities, but also strong political involvement both in the home country and in the receiving states (Meintel, 2002). These transnational ties have certainly fostered improvements in the standard of life of many families. Yet they also contribute to the accentuation of natives' perceptions of socio-economic differences in regard to their relatives and friends abroad. Life-styles in other countries are often the subject of conversation during home visits. It is also displayed by the gifts brought each summer and exhibited through luxurious items for personal use such as mobile phones. Return migrants frequently build their houses in the same fashion as in the receiving countries, importing furniture and electronic appliances. In Brava one can easily find *casas americanas* and in São Vicente *casas holandesas*. In addition, new businesses make imported products available generating curiosity and creating new needs. But homecoming, either to re-settle or just for vacation, is always very costly. Migrants are expected to sponsor the Saints' feasts, distribute gifts and contribute with financial aid to relatives and friends. Those who cannot fulfil these expectations often opt for not returning, as the rumour they did not do well abroad would soon be spread (Meintel, 1984b). People in the islands are thus mostly exposed to the benefits of emigration and the outcomes of such benefits are displayed in such a noticeable manner they become part of people's daily lives.

A study by Carling (2001), conducted in São Vicente and Santo Antão, reveals that teenagers in their last school years perceive the achievement of a better life in two ideal ways: 1) by studying abroad and work a few years in another country before returning home to make their way up in the social ladder and 2) by emigrating and coming back home once a favourable socio-economic status has been reached. The author goes on to explain that pursuing higher education abroad is not perceived as emigrating, rather, it is a temporary process to gain expertise which will be put in practice in Cape Verde. This process is also viewed as preferable to *de facto* migration. However, study scholarships are scarce and most students soon see this path as not feasible. Expectations of getting a better life are thus left to be fulfilled by turning to emigration. This is not to say emigration is comparatively a much easier path. In the case of emigration to Northwest Europe that is all but the case. Yet, the odds for emigrating are not limited by a short period to make a decision as in the case of potential higher education students. The distribution of scholarships is often dependent on selective criteria that exclude those long-graduated from high school. Conversely, given the time-costly process of family reunification, the hope that a Cape Verdean emigrant gathers the conditions to send out for a relative may be extended for years. At the same time, the social environment, depicted above, acts strongly in keeping the benefits of emigration visible. If we take into consideration that the unemployment rate reaches up to 25% of the population then it is not surprising that emigration is perceived as a paramount way for social upward mobility.

All together, the circumstances just described favour the maintenance of strong aspirations to emigrate. Nonetheless, years go by until some are able to fulfil such wishes. Many others remain in the country as involuntary non-migrants. This condition of undesirable immobility is made even starker by the extensive transnational activity of emigrants (Carling, 2002). This generates a somewhat paradoxical situation. While the migrants' transnationalism contributes to an increase of life standards in Cape Verde it nevertheless sharpens social contrasts, intensifying the wish to leave. Those who cannot do so experience the 'second-hand' benefits of emigration in the hope that their dream will become reality. The Cape Verdean migration phenomenon is thus not only lived by those already abroad but it is widely part of the imaginary and everyday lives of those who are unable to move. As one of my informants put it: "I am trying to bring my children to the Netherlands for ten years. It does not seem to work. I keep sending them money every time I can. It is very difficult. (...) I just got a letter from them. They ask me to send them clothing. They want to dress like the teenagers from over here".

On a recent study, Åkesson notes, however, that in the past years ideas about life abroad have become more "ambiguous and pessimistic" and those who remain in Cape Verde have now a "more nuance image" of what migration really entails (2005: 5). The improved access to telephones, Internet and transportation have contributed for an intensification of both virtual and real contact between migrants and their families and friends at home. Non-migrants are thus better able to realize the difficulties encountered by their compatriots abroad and this has contributed for a demystification of the West as an "El Dorado". Nevertheless, Cape Verdeans show a resilient impetus for migration. No matter which difficulties arise, Cape Verdeans will continue to make incredible efforts for pursuing a life abroad – "being a Cape Verdean means being predestined for mobility" (Åkesson, 2005: 14).

1.3 Theoretical considerations on Cape Verdean migration

The features characterising Cape Verde's long-term history of migration make it a relevant case study for international migration scholars. It is not on the scope of this essay to provide an exhaustive theoretical analysis of Cape Verdean emigration. Nevertheless, a theoretical account of that process reveals itself valuable at two levels. First, almost one hundred and fifty years of Cape Verdean migration serve to illustrate Massey's point that 'all theories play some role in accounting for international migration, although different models predominate at different phases of the migration process (1998:281). Second, it allows for a better understanding of how Cape Verdean immigrants settle in the receiving societies and the sort of relationships they develop there.

According to França, three main conditions have been stimulating migration from Cape Verde since the nineteenth century: the fragile economy, the rapid demographic growth and frequent and long-lasting draughts (1992:41). As mentioned before, self-sustaining food production has been a problem in Cape Verde since its early times as a colony. Most arable land was by then at the hands of a few white families. Real profits were to be taken out from the slave trade and from the contraband arising from inefficient enforcement of metropolitan prohibitions. These conditions facilitated other sources of income and owners soon left their lands abandoned. As draughts hit the islands recurrently, no action was taken to prevent soil erosion. The land became increasingly unproductive leaving a substantial labour force out of work and out of food (Meintel, 1983). At the same time, since the end of the nineteenth century up to the mid twentieth century, several countries experienced the need for extra labourers. That was much the case with the United Sta-

tes, Portugal and the Netherlands. The first Cape Verdean emigrants left as a means of minimizing the negative effects of the draughts and of under- or unemployment for themselves and their families. By allocating one member of the household outside borders to a more trust-worthy and higher source of income many families found a strategy for reducing risks to subsistence (as explained by the *new economics of labour migration theory*). This feature of early Cape Verdean migration is still present today, as can be observed by the great volume of remittances sent to Cape Verde each year (Carling, 2001).

The first Cape Verdean emigrants were men who found work on the American whaling industry. As the whalers travelled back and forth, making frequent stops on the islands, news about better paid work spread easily and more often than not ships returned with new crewmembers. Young single men already working on the ships also seized these return opportunities to courtship and marry. In many cases, long years went by until they saw their wives and children again. Some of those men found work ashore and began to sponsor friends and relatives to join them. They worked mostly on the seasonal cranberry bogs and at the docks. With the end of the American Civil War industrialisation boomed. This led to a massive drain of manpower for the textile industry in the cities. Many farms were abandoned and work on the whalers was no longer found attractive. The Cape Verdeans took over the dying whaling industry as well as the seasonal labour of the cranberry bogs (Meintel, 2002). Because the rest of the population did not want to take part on these jobs an economic enclave took form (as assumed by the *segmented labour market theory*) which made possible the arrival and incorporation of new immigrants. Once new vacancies opened, for instance in a whaler, the new crewmembers were chosen by the existent Cape Verdean crew. The new member was more likely than not a Cape Verdean. Furthermore, as most Cape Verdeans concentrated in the area of Massachussets, especially in New Bedford, newcomers could often count with the help of not one but several family members and relatives who in many cases had already funded their trips. In this sense, migration flows grew stimulated and sponsored by migrant networks (*social capital theory*). The same process has taken place with Cape Verdean emigration to the Netherlands and, later on, to other countries such as Portugal, Italy and France.

As more and more Cape Verdeans settled abroad the volume of remittances grew at a steady pace stimulating new daily needs and leading to the monetarization of the economy. At the same time, differences on income distribution rose. Yet, because of the environmental conditions described above and the lack of external help, Cape Verde's production sector remained in

deficit and its economy unsustainable. This led to increasing socio-economic differences between households with one or more members abroad and households with no emigrant members. Because no other alternatives were seen to exist pressure to emigrate increased (*theory of cumulative causation*). In this way, the benefits and desirability to migrate have been transmitted to children since a very early age and emigration remains up to this day a strongly desired event.

Cape Verdeans can be found a bit all over the world nowadays. Some engaged on several jobs and worked in different places returning after a few years of higher earnings. Others awaited their pensions and returned to the islands soon after they got them. Many settled permanently on the host societies. Yet a characteristic common to all Cape Verdean emigrants was the intense contact kept with Cape Verde. When the first seamen left in the mid-nineteenth century, those who were still bachelors chose more often than not to return to the islands and use their savings to establish a household. After a brief courtship and marriage the husband returned to the sea or to the receiving country. In most cases years went by between each home visit and many more had to pass until the family got finally reunited. In the meantime, many letters were written but families communicated mostly through *mantenhas*[10] , or oral messages, brought by friends and relatives each time they travelled. During the periods of absence the household in Cape Verde was supported through the remittances sent from abroad. When immigration laws in the United States tightened many kept promoting the entrance of relatives and friends into the country via marriage. At that time, Cape Verdeans began to emigrate towards other destinies of which Europe became the main receiving continent. The tendency for stringent immigration policies was also felt in European host countries. Networks of friends and relatives remained the key-solution for making emigration possible.

Since independence Cape Verdean emigration has increased and diversified in terms of gender and class. Today's migrants, male and female, schooled and unschooled, often move from one country to another before settling down. This has become possible not only because recent migrants show greater family dispersal than in the past but also because there are active voluntary associations and newspapers which help to provide information about the conditions at the destination countries and about Cape Verde. Cape Verdean emigrants also act in support of their fellow countrymen in Cape Verde making collective donations to build schools and waterworks. They gather

10. According to Meintel (2002) *mantenhas* derived from the Portuguese verb *manter* which means to maintain.

provisions and invest to improve tourism increasing the country's possibilities foreign investment. Furthermore, they have been committed to politics both in the host societies and in the homeland. With the improvement of travelling conditions and new technological developments such as Internet Cape Verdean emigrants' connections with the home country remain considerably active. In face of this, Meintel (2002) adverts that transnationalism as always been a present feature of Cape Verdean migration. The ties of kinship, sentiment, values, commerce and so on represent only one aspect of this transnationalism. Today, Cape Verdean emigrants sustain a great deal of contact and exchange with other dispersed Cape Verdean migrant communities which are not mediated by the homeland. These happenings mirror the idea that the 'Cape Verdean community' knows no borders and can be termed a diaspora (Meintel, 2002: 39).

1.4 Cape Verdean immigrants in the Netherlands

1.4.1 Migration to the Netherlands

Cape Verdean migration to the Netherlands began in the 1950s gaining momentum in the mid-1960s. Like it happened a century before with migration to the United States, the first Cape Verdeans to settle in the Netherlands were seamen employed on commercial ships who later found jobs ashore the Rotterdam area. Most of these men were from São Nicolau and Santo Antão. Soon after settlement they began to sponsor other newcomers' arrivals first by paying for travel expenses and helping with accommodation and later on through family reunification and family formation. At present, the majority of Cape Verdeans immigrants in the Netherlands still live in Rotterdam (Carling, 2003).

Three phases of Cape Verdean immigration to the Netherlands can be identified which relate directly to shifts on immigration policy in the host country and political changes in the motherland. The first phase of immigration took place between the 1950's and Cape Verde's independence in 1975. Most people arriving during this period did not intend to settle permanently. Rather, they expected to benefit from the better labour conditions and return once savings were gathered. Already back then were immigration policies tightening. Cape Verdean seamen were hard workers and cheaper than other sailors. They helped other countrymen join in the ships and between 1958 and late 1960s their number increased from 20 to 700. Meanwhile, some of those men found work ashore. They began to bring their wives and children but also to sponsor other Cape Verdean workers. With the independence

of Cape Verde labour migration became substantially more difficult. Nevertheless, many students, former military staff members, schoolteachers and other civil servants who were dissatisfied with the political circumstances, migrated to the Netherlands. Many of these migrants were able to stay permanently by marrying Dutch citizens. This second phase of immigration was thus marked by a shift from low to high qualified migrants but, especially, from labour migration to family reunification. In the years after Cape Verde's independence changes in the Dutch law allowed for all those who worked for more than seven years on ships to gain Dutch nationality. Many Cape Verdean seamen seized this opportunity and brought their families to the Netherlands. By the mid-1980s most families were reunited. At the same time, many Cape Verdeans visited their families in the Netherlands, overstaying their tourist visas and becoming irregular migrants. Some regularise their status later on. Others remain undocumented.

The third phase of Cape Verdean migration began after 1991 when the first multi-party elections were held in Cape Verde. Highly-educated people as well as students pursuing education abroad and trying to find better jobs constituted to a great extent the new bulk of immigration. There was also a very strong female component in these new migratory flows. Many women migrated first to Portugal and Italy where they worked as domestic workers and waited for an opportunity to travel to the Netherlands (Gemeentearchief Rotterdam *et al.*, 2002). But in the early 1990s labour migration was already almost impossible. Many of the new migrants found their way in through marriage. Once again, like it happened with immigration to the United States after the stringent laws of the 1920s (Meintel, 1984b), many of these unions were 'fixed marriages'. Although some married out of love, most got their residence permits by marrying friends or relatives. Others had to pay substantial sums of money for a forged marriage. Through the 1990s a large number of asylum seekers arrived to the Netherlands and the government imposed even more restrictive immigration policies. Marriage to Dutch citizens no longer allowed for gaining a Dutch passport in a matter of days, as in the early 1990s. In fact, years had to pass until the newly arrived spouse could get a permanent residence. Additionally, only people reaching above a certain minimum income were allowed to make a request for bringing in relatives or future spouses. Marriages began to be controlled by immigration officials who visited homes regularly. Since 2002, if an application for marrying a Cape Verdean citizen is to be made, it must be filed from Cape Verde itself. The immigration law concerned with family formation was once again revised recently and tightened even further. Since November 2004, the Dutch "sponsor" must be on the hold of a labour contract of at least a year, enti-

tling him to an income which amounts to 120% of the net minimum wage in order to make a request for his foreign partner to come to the Netherlands (Goudsmit, 2004). Furthermore, before entering the Netherlands the foreign spouse must prove basic competencies on Dutch language and culture. These days, it is considerably difficult for any non EU-citizen to migrate to the Netherlands[11] and Cape Verdean migration is slowing down.

1.4.2 Population demographic profile

The Netherlands hosts the second largest Cape Verdean community in Europe, composed by 19,919 people[12] (CBS, 2005). It is a considerably young population: 28% are younger than 15 years old, 67% are younger than 35 years old and only 2% are above 64 (ISEO/COS, 2001). Most Cape Verdeans in the Netherlands have Dutch nationality (85% in 1996 (Bol, 1998). Yet, the majority of people preserve dual citizenship, i.e., Cape Verdean and Dutch nationality. Many others hold Portuguese passports and fall into the category of North Mediterraneans. This situation makes it difficult to know if the statistics fully cover for all persons of Cape Verdean background living in the Netherlands. Furthermore, it is estimated that between 2000 and 3000 undocumented Cape Verdeans live in Rotterdam (Avanço, 2000 in Gruijter, 2003).

There is an unbalanced spatial distribution of Cape Verdeans in the Netherlands, with a clear preponderance for the region of Rotterdam[13]. Within the city Rotterdam, the submunicipalities of Delfshaven and Feyenoord host more than half of the Cape Verdean population, 43% and 11% respectively (COS, 2002 in Gruijter, 2003). In the past years, a tendency to move from the city centre to the suburbs (e.g. Spijkenisse and Capelle aan de Ijssel) has been observed (Carling, 2003). This tendency might be explained by problems related to unemployment and drug use and trafficking in those neighbourhoods. The following table shows Cape Verdeans' main areas of residence in the Netherlands.

11. An exception to this situation is the case of migrants who fall into the category of "knowledge migrants", applicable since October 2004. This category includes three sub-categories: 1) individuals with gross annual earnings amounting to Ð45.000 qualify as a "knowledge migrant" (for people below 30 years of age an income of Ð32.600 suffices), or 2) individuals who are employed as graduates, or 3) individuals employed as PhD students or university lecturers, who have not yet reached the age of 30 (Kroes, 2004).
12. This figure is calculated based on the definition of immigrants employed by Statistics Netherlands – CBS in the Netherlands, i.e., all individuals who have at least one parent born abroad. 58% of the Cape Verdeans in the Netherlands are first generation immigrants (CBS, 2005).
13. Rotterdam has a population of about 600,000 people. About 47% are alochtonous.

Table 2. Geographical distribution of Cape Verdean residents in the Netherlands

	Living areas	Residents	Proportion of Total
Rotterdam Region	Rotterdam Schiedam Spijkenisse Capelle a/d Ijssel	14 755 680 315 300	78% 4% 2% 2%
Partial Total		16 465	87%
Other Cities in The Netherlands	Amsterdam Zaanstad The Hague Delfzij	560 500 250 220	3% 3% 3% 3%
Partial Total		2 545	13%
TOTAL		19 010	100%

Source: Statistics Netherlands in Carling (2003).

Most Cape Verdeans live in neighbourhoods where people are confronted with serious problems of unemployment and dependency on social welfare. Nevertheless, a study conducted in 1995 concluded that 70% of the Cape Verdeans had a paid job. This is a significantly high percentage if compared to Dutch natives (43%) (Bol, 1998). Yet, Cape Verdeans tend to have low-qualified and poorly paid jobs. Most women find jobs on the cleaning industry and men are often employed at the harbour or on the construction sector. Household incomes are often very low and many people experience dramatic problems with debts. When talking with my key-informants, all of them social workers, I was told debts are one of the main reasons by which people seek help. Other common problems in the community relate to single-parenthood and teenage pregnancy. 27% of Cape Verdean families are constituted by only one of the parents (COS, 2002 in Gruijter, 2003). This is usually the mother. Although authority is reserved mainly to the father, mothers take most responsibilities in the household, especially in what concerns the health and education of the children (Meintel, 1984a). Single parents' households face a greater risk of falling into debts. The same is valid for teenage mothers who also run the risk of abandoning school, minimizing the possibilities of achieving higher incomes in the future.

Educational achievement of Cape Verdean children is lagging behind that of the general population. On primary school tests, 66% of the boys and 63% of the girls score below average (ISEO/COS, 2001). Possible explanations for these results lie on the long working hours undertaken by parents, single-

parenthood and low education levels among Cape Verdean adults who might experience little availability to accompany their children on the studies. 55% of the Cape Verdeans in Rotterdam seeking for a job are illiterate or have primary school and 34% have general education or lower to intermediate vocational training (ISEO-COS, 2001).

Cape Verdeans are predominantly Catholics. The presence of the Roman Catholic Church in Cape Verde is certainly related to the influence of the Portuguese colonisers (Meintel, 1984a). Nevertheless, there are a substantial number of followers of other sects and doctrines. In the Netherlands that is also the case. Between 60% and 80% of the Cape Verdean community are Catholics. Also a great number of people attend the services from the Universal Church of the Kingdom of God (Igreja Universal do Reino de Deus), a Brazilian Pentecostal sect. Others follow a doctrine designated Christian Racionalism (Racionalismo Cristão) which has been gaining momentum since the 1990s (Beijers, 2004).

Cape Verdeans in the Netherlands communicate in three different languages: Dutch, Kriol and Portuguese. Learning the Dutch language was a big challenge for most first generation immigrants. Nowadays, language courses are compulsory for all alochtonous people. As 40% of the community has been born in the Netherlands, Dutch is probably the language most widely used in daily life. Nevertheless, Kriol remains the language uniting the community and it is broadly used in official and social events. Also, most Cape Verdean parents stimulate their children to learn Kriol and frequently use it at home. Portuguese occupies only a marginal position in the communication dynamics of Cape Verdeans in the Netherlands. Despite being Cape Verde's official language it is often used for writing only, as Kriol is not yet an established written language. Most young Cape Verdeans can understand some Portuguese but not write or speak it (Carling, 2003). I have noticed they tend to speak mostly in Dutch even if among other second generation Cape Verdeans. As for the older people it seemed to be the contrary. Although many speak good Dutch they address each other mostly in Kriol, incorporating several Dutch words during the dialogues.

Cape Verdeans are extremely socially active people. They often organise parties and music and sports events. They also account for the creation and management of more than seventy organisations in the Netherlands (Gruijter, 2003; Da Graça, 2005).

1.4.3 Ascribed Identity and Social Recognition

Issues relating to the identity, ethnicity and social recognition of the Cape Verdeans remain widely unresearched in the case of the Netherlands. In the Dutch public discourse Cape Verdeans are often referred to as 'silent migrants'. This label is coupled with the idea that Cape Verdeans migrants are self-reliant, quiet and introvert. They are also perceived as somewhat isolated and not well-integrated but nevertheless unproblematic migrants. This is especially the case with the first generation (Beijers, 2004).

This situation seems to be changing for the second generation. Younger Cape Verdeans are perceived to be mingling with other groups and to no longer experience the language difficulties their parents did. They are also credited for an innovative music style which blends rap with traditional Cape Verdean music rhythms. Yet a few years ago some youngsters were targeted for participating in criminal acts in Rotterdam. The involvement of Cape Verdeans in such acts was faced with surprised by the police authorities who had had no contact with the community until then. As one of the social workers I talked to explained: "a few years ago there was some 'movement' in the Cape Verdean community, especially with the youngsters. They were becoming defiant and undisciplined. Until then the authorities had never come across Cape Verdeans. They did not know us because we had always been *stille migranten* ('silent migrants'). They knew that we lived here in Rotterdam but we were kind of invisible. They had no problems with us. They knew we come from Cape Verde and that we are hard workers and that was all".

Scholars from the United States have discussed extensively the issue of invisibility brought up in the explanation provided above. Until 1980 Cape Verdeans were not included in the American Census nor were they given social representation. This lack of recognition can partly be explained by the small size of the migrant population and its former colonial ties to Portugal. However, 'race relations' seem to have played a chief role in the ascribed identity of Cape Verdean Americans. According to Halter (1993), racial classification in the United States has been historically an oversimplified matter of 'black' and 'white' and this dichotomy virtually obliterated cultural differences among people of colour. Although Cape Verdeans sought recognition as white Portuguese Americans the latter soon excluded them. At the same time, Cape Verdeans chose not to identify with the American blacks. The end result of the lack of identification with one of the socially recognised 'racial poles' was an ever re-definable ascribed identity which characterized them as "neither black nor white, but sometimes white, at other times black, Afri-

can, Portuguese, brown even green[14]" (Halter, 1993: 14). These irreconcilable identities placed Cape Verdeans in a fragile social position, hampering the recognition of this group as one of the minorities within the United States and subsequently inhibiting their entitlement to state developed programmes and funds attributable on the basis of ethnic/racial origin.

In the Netherlands this discussion does not seem to fall so openly within the limits of 'racial identification'. Nevertheless, a parallel can be found with the social status of Cape Verdeans in the United States. If the public discourse addresses Cape Verdeans as 'silent migrants' only recently did official policy stop treating them in the same silent way. Cape Verdeans do not fit in on any of the main migrant categories in the Netherlands. They were not part of the labour recruitment programmes, they have no colonial bonds with the Netherlands and they are not refugees. Thus, they have been largely neglected by the official migrant policy and they have had limited political participation. Furthermore, only in recent years have they been included on the scientific discourse on migration. At the same time, Cape Verdeans are portrayed as a non-demanding, quiet and docile group. These ascribed characteristics are often coupled, although many times in a concealed way, with a denied right for making demands. By placing Cape Verdeans into the category of 'silent migrants' society finds a way to almost legitimise the expectations that these migrants should not complain about any hardships. However, Cape Verdeans seem to feel themselves differently and they are strongly committed to improve the community's life. One example of this is the substantial number of voluntary associations and organisations developed by Cape Verdeans in the Netherlands. They have revealed themselves particularly active on the field of health care (Beijers, 2004). This involvement will be discussed in section 2.4. Still, concerning social recognition, in the Netherlands as in the United States, Cape Verdeans remain a minority among minorities. This condition associated to strong expectations inherent to an image of 'silent migrants' might hinder integration and pose a barrier to social participation.

14. When unable to classify Cape Verdeans by race some referred to them as the 'green people', taking the translation of Cape Verde literally (Halter, 1993).

2

MIGRANTS' MENTAL HEALTH AND ACCESS TO HEALTH CARE

In the past decade migrants' access to health care has become topic of increasing debate in the Netherlands. This chapter attempts to provide some insight on this question. It first presents an overview of the data available concerning migrants' state of health. It continues with a description of the organizational characteristics of the Dutch health system, placing attention into the high degree of compartmentalisation of the system. Thirdly, the matter of access to care is discussed at a general level for all migrant groups. Finally, it focuses on the case of Cape Verdean immigrants reflecting on the possible determinants that might lead to the underuse of mental health care.

2.1 The health situation of migrants

Migrants constitute about 10% of the population in the Netherlands (1.623,000) (Social en Cultureel Planbureau, 2003). Since the period following World War II three core groups of migrants have settled in the Netherlands. The first group is composed by the so-called 'guest workers'. They arrived mainly during the 1960s up to the mid 1970s as part of a recruitment program developed by the Dutch government in order to compensate for the large labour shortages caused by rapid economic growth. These migrants were imported mostly from the Mediterranean region. The Turks and the Moroccans became the largest populations. Migrants from Suriname and the Netherlands Antilles and Aruba constitute the second group, arriving mostly during the 1970s. These migrant populations are often coupled together. It should be borne in mind, however, that their arrival to the Netherlands was motivated by different factors. While the Surinamese migrated as a consequence of the political instability deriving from independence the Antilleans left due to the economic problems faced by the islands. Furthermore, the latter are still part of the Dutch Kingdom and face no restrictions of entry to the Netherlands (Lucassen and Penninx, 1997). Together, these two migrant groups amount to two thirds of the total migrant population in the Netherlands. They include: 341,000 Turkish, 321,000 Surinamese, 295,000 Moroccans and 129,000 Antilleans. Refugees compose the third group of migrants. They have been arriving since the early 1990s coming predominantly from the following countries: Iraq (42,000), China (39,000), Afghanistan (34,000), Somalia (28,000) and Iran (28,000) (Social en Cultureel Planbureau, 2003). Moluccans, Spaniards, Italians, Cape Verdeans and people from former Yugoslavia compose other smaller migrant populations.

The following intends to present a general overview of migrants' state of health, with special focus for mental health. Prior to this description, an account of the theoretical and methodological limitations of the studies conducted in the Netherlands will be provided. In the end reflection will be put into how migrants are portrayed in regard to health status and health behaviour.

There are several ways by which migrants' health situation can be approached: epidemiological studies, perceived health and presented health problems, psychological problems and use of health care services (Van Dijk and Van Dongen, 2000). It is considerably difficult to characterise migrants' health situation in the Netherlands. Several pitfalls have been encountered on the existing studies which undermine the understanding of the determinants of migrants' health and illness. First, there is an unbalanced focus of research towards the study of Moroccan and Turkish groups and, to a smaller extent, of Surinamese. Little is known about the other migrant groups such as the Cape Verdeans, the Chinese or the Molluccans (Mackenbach, 1996). Second, many of the studies do not allow for an accurate identification of the factors influencing health nor do they make clear which variations in health exist between and within migrant groups. Third, most research is conducted by health professionals or researchers affiliated with health care services and study populations tend to be selected exclusively from within the group of migrants who use Dutch health care services. This approach largely neglects an extensive part of the migrant population who is not ill. Furthermore, it does not allow to gain insight about alternative ways of seeking for health care. Finally, the existing research is essentially descriptive lacking theoretical foundation (Van Dijk and Van Dongen, 2000). This might bring considerable problems for the validity of data, especially in what regards mental health where differences in diagnoses often arise from the use of different criteria concerning the distinction between 'mental' and 'physical' problems (Ingleby, 2003b).

Despite these limitations, and the fact that studies' results are rather diverse and often incomplete (Knispscheer *et al*, 2000), there are strong indications of differences in the health status and mortality patterns between migrants and indigenous populations (Venema, Garretsen and Van der Maas, 1995; Stronks, Ravelli and Reijnfeld, 2001). A report recently released by the National Institute for Public Health and the Environment (RIVM) confirms these differences. The report shows that "health is distributed unequally in the Netherlands, with considerable differences between rich and poor, city and countryside, indigenous Dutch and members of ethnic minorities". Lower levels of health appear associated with poor living conditions in inner-city

neighbourhoods, low degree of education, joblessness and socio-economical deprivation (Van der Oers, 2003). These conditions are experienced to a greater degree by ethnic minorities when compared to indigenous Dutch (Knipscheer, 2000).

Considerable evidence exists proving higher mortality rates among migrants. Surinamese and Antillean migrants experience a mortality rate 20% higher than that of Dutch indigenous (Tas, 1992 in Venema *et al*, 1995). Mortality among Turkish and Moroccan migrant children is also much higher than for the native population. For the age group between 1 and 5 years of age, this rate is about 2,5-3 times higher than for the total population. Infectious diseases, external causes (e.g. traffic accidents), congenital diseases and, in the case of girls, diseases of the respiratory system, are more often causes of death for Turkish children than for their Dutch peers. The same is valid for Moroccan children with the exception that diseases of the respiratory system are more common with boys and congenial diseases with girls (Hoogenboezem and Israëls, 1990 in Venema *et al*, 1995). However, life expectancy among older migrant populations does not differ much from that of the Dutch natives. For example, men of Moroccan origin live on average 3.5 years longer than Dutch men, while Turkish and Surinamese male migrants have a life expectancy which is about 1.5 years lower than that of Dutch native males. Turkish and Antillean women have roughly the same life expectancy of Dutch women and women of Moroccan background tend to live a year less (Statistics Netherlands in Van der Oers, 2003).

There seems to be a higher prevalence of certain health problems among migrants. This is particularly valid for chronic illnesses. Turkish migrants tend to experience stomach ulcers and low back pain more frequently. Surinamese and Turkish children report more often psychosomatic complaints (Venema *et al*, 1995). A greater incidence of thalassemia major exists among Turks and Moroccans and sickle cell anaemia is more prevalent among Surinamese and Antilleans (Van Dijk and Van Dongen, 2000). Furthermore, symptoms connected to depression, sleeping disorders, insecurity, homesickness and loss of self-esteem have also been more frequently reported among migrants (Knipscheer, 2000). Additionally, migrants tend to rate lower on self-perceived health. Turkish and Moroccan adult migrants and Surinamese and Moroccan teenagers are more likely to rate their own health significantly less often as 'good' when compared to Dutch natives (Venema *et al*, 1995; Stronks, Ravelli and Reijnveld, 2001).

Data concerning migrants' mental health in the Netherlands remains rather incomplete (Knipscheer, 2000). However, it is generally accepted that migrants enjoy poorer mental health when compared to Dutch natives (De Jong, 1996; Maas, 1997; Venema, Schulpen and Van Wersch, 1998 in Van Dijk and Van Dongen, 2000). Epidemiological studies on this area have put strong emphasis on the study of psychotic disorders. Among these, the incidence of schizophrenia as been the most studied. When compared to the Dutch native population migrants are incomparably more diagnosed with this disorder. A study based on admission rates for schizophrenia and other forms of non-affective psychoses found higher frequency of admissions for Surinamese, Antilleans and Moroccans (Selten and Sbijen, 1994). Using data of the administrative departments from almost all institutions for in-patient care in the Netherlands, Selten, Slaets and Kahn (1997) confirmed the findings of the previous study. The authors concluded that Surinamese and Antillean-born migrants presented a risk of incidence of schizophrenia three to four times higher than Dutch natives. Another recent study conducted in Rotterdam compared the incidence of treated schizophrenia at outpatient mental health services between Dutch natives and immigrants. The conclusions of this study showed a significantly higher prevalence of treated schizophrenia among female migrants from the Antilles, Suriname and Cape Verde as well as for male migrants from Suriname and Morocco (Schrier *et al*, 2001).

In face of the information just provided how are migrants portrayed in relation to health and health care practices? In the Netherlands, as in a number of other places in the world, many share the idea that migrants have 'exotic' ways of dealing with health and illness. The media contributes to enforce these ideas futher. Its focus falls mostly on the display of 'strange' rituals performed by some within migrant groups, such as exorcisms carried out by Moroccan healers. Migrants are often portrayed as the 'other'. The fact that 'they have culture' makes them different. This message also seems to prevail in official and scientific publications on migrants' health (Van Dijk and Van Dongen, 2000). The fact that little is known about what keeps migrants healthy contributes for a stronger impact of studies focusing on highly stigmatised pathologies in the eyes of the lay people, such as psychosis. When epidemiological studies report that 'migration from the Caribbean and from Surinam is a risk factor for schizophrenia' (Selten *et al*, 1997:811), without providing any theoretical insight on the impact of environmental factors at the host country, the danger of isolating migration and migrants themselves as a problem emerges. As Littlewood and Lipsedge (1989) put it "it is only a simple jump from perceiving a group as *having a problem*, then studying it exhaustively without any contextual knowledge, to then perceiving the group

itself as *being a problem*" (Ibid: 257, the italic was kept from the original). In the Netherlands, this seems to have become the case. Migrants are often defined either as risk or problem groups. They are also often considered problematic patients (Van Dijk and Van Dongen, 2000).

2.2 The Dutch health care system – an overview

Health care in the Netherlands originates largely from the efforts of voluntary organisations many of which are ran along religious and ideological lines. The government regulates the Dutch health care system and the Health Inspectorate is responsible for monitoring the quality of health services and health protection measures (De Ruuk, 2003).

Health care provision is divided in four sectors: basic care, commonly known as zero-line care; primary care; secondary and tertiary care; and, social care. Zero-line care is provided through a limited public health system with local offices spread through the country. Primary care is provided by general practitioners, district nurses, home caregivers, midwives, physiotherapists, social workers, dentists and pharmacists. Each user must be registered with a general practitioner. Referral to specialists or hospital care is made possible through general practitioners. Secondary and tertiary care are largely supplied by private non-profiting organisations. Social care includes both mental health care and nursing care.

The following provides an overview of the scope of intervention of each of these sectors[15]:

1. Zero-line care
Zero-line care is concerned with public health and is organised in municipal and district services. These services assure diagnostic and preventive care, epidemiological investigations, administration of health laws and advice on health and health related matters. Local public health includes infectious diseases control, general hygiene, school health and public health education, and information on child rearing. This sort of care is provided by municipal public health services – Gemeentelijke Gezondheidsdienst (GGD).

2. Primary health care
Primary care is mostly provided by general practitioners (GPs). These

15. Source: European Observatory on Health Care Systems (2002).

professionals hold a function as gatekeepers to the health care system. Users do not have free access to specialists or hospital care. In order to use those services, patients must have a referral letter from their GPs.

General practitioners are specialized in common and minor diseases, care for patients with chronic illnesses and in addressing the psychosocial problems related to those complaints. Complicated non-comprehensive (and extensive) specialist care is reserved for patients who require specific expertise and highly technical skills. GPs maintain independent and mostly individual practices in each community. The average number of patients per general practitioner is 2,300. Primary care constitutes about two thirds of all contacts in ambulatory care.

3. Secondary and tertiary care
Secondary and tertiary care is mostly provided by medical specialists. Except in case of emergency, patients are not allowed to go directly to an outpatient department or polyclinic of an acute care hospital.

4. Social Care
Social care includes both mental health care and nursing care.

4.1 Mental Health Care
Mental health care has expanded significantly in the last decades. Recent studies estimate in 500,000 the number of people seeking for this kind of services each year. The government has encouraged policies promoting the integration of ambulatory and institutional care at a regional level. The main principle underlining such policy was the creation of flexible, integrated, patient-friendly and effective care with an emphasis for ambulatory rather than instutionalised mental care (Ministry of Health, Welfare and Sport, 2001 in De Ruuk, 2003). Whether this policy has been successful or not will be discussed in the following section.

The most practical result of this policy was the creation of three echelons around which mental health care services are organised:
1) Out-patient care
This type of services encompass independent psychiatrists and psychotherapists, Regional Institutes for Out-patient Mental Health Care (RIAGG), out-patient clinics at hospitals and out-patient addiction care centres.

RIAGGs provide treatment, guidance, prevention and advice and a 24-hour crisis service to young and adult people, including the elderly. Independent working psychiatrists and psychologists mostly provide for the adult population. Out-patient clinics focus on treatment and guidance offering in some cases specialised care. Addiction centres target specifically for people in need for rehabilitation. In the last years, these centres have merged with larger institutions.
Every year 450,000 new patients receive care in these facilities.

2) Semi-residential care
This echelon includes sheltered accommodation, psychiatric part-time treatment, day centres and day nurseries. Semi-residential facilities house people who do not qualify or can no longer make use of in-patient facilities and for whom out-patient care is found inappropriate.

Sheltered accommodation provides care for people in need of support and guidance in everyday life. It receives 1,300 new clients each year. Part-time treatment is provided at child and adolescent psychiatry services, addiction care and forensic psychiatry. Day nurseries offer part-time care to children between the ages of 2 and 7 and to their parents. Annually, 17,000 people make use of part-time treatment. Day centres provide for people with a long past of psychiatric problems.

3) In-patient care
The third echelon comprises a wide range of institutions and facilities which include psychiatric hospitals, child and adolescent psychiatric care and addiction care.
More than 90,000 admissions for in-patient care take place each year.

In the last years, an increasing tendency towards the abolishment of the echelons in mental health care provision has been taking place. A great number of mental health care services have merged giving place to local and regional agencies with a wider scope of intervention (De Ruuk, 2003). It is nevertheless important to emphasise that access to mental health care is made possible only by GPs' referral. Acute and crisis situations are the only exceptions in which contact with mental health care services can be made directly.

4.2 Nursing Care
Nursing care includes nursing homes and homes for the elderly or residential homes. The latter provide for people with disabilities, lack of social contacts and/or who feel unsafe in an independent house.

> Residential homes offer the possibility to do courses on a daily basis and have a general practitioner who assures medical care.
> There are two kinds of nursing homes: somatic and psychogeriatric. The latter offer support for elderly patients with mental deterioration, often dementia. Somatic nursing homes provide multidisciplinary treatment and monitoring for disabled people who cannot live alone.

As it can be concluded from what is described above the Dutch health care system is highly compartmentalised. That fragmentation is especially evident within the provision of mental health care. In the city of Rotterdam alone there are at least six different mental health care services, each with its own approach and target population. Some of the informants of this study remarked they had contact with several services before being finally sent to the service (or department) most suited to their needs. In between those trials, referrals were always made via the general practitioner. It is not within the functions of these professionals to make psychological diagnoses yet their key function as the health care system gatekeepers inevitably demands the knowledge about other existing services. It appears that even for general practitioners it is sometimes difficult to find a way through this intricate system. The following section attempts to provide an overview of migrants' access to health care.

2.3 Migrants' access to health care

Accessible health care for migrants is defined as care with which migrants are familiar with, which they are able to make use of and which assists and treats them in an adequate and satisfactory way (Van Dijk, 2003). This implies a match between the help offered and the needs of the people receiving it. In other words, accessible care is care that makes sense to its users (Ingleby, 2003a).

At least four decades of concern with migrants' health can be mapped within the Dutch health policy. Roughly, each of these decades has been marked by a shift on the philosophy of care and on the services available for migrants. These shifts are associated with the wider political context and different perspectives on migrants' integration (Van Dijk, 2003).

During the 1960s, actions concerning migrants' health mirrored the governments' belief that the newly arrived 'guest workers' were only staying in the Netherlands temporarily. Migrants were expected to leave once labour needs were reduced. Integration was therefore not an issue. Health policy

was merely concerned with preventing migrants from becoming a threat to public health and focus was put exclusively on the control of infectious diseases such as tuberculosis and venereal diseases (Van Dongen, 2003). With the 1970s came the governments' awareness of what social scientists had long been calling attention for: migrants were there to stay and their families were arriving to join them (Vermeulen and Penninx, 2000). By this time, general practitioners stood up arguing that infectious diseases were only a marginal problem. Attention thus shifted towards psychosomatic complaints, deficiency diseases such as rickets and exotic illnesses like demon possession. These health problems had not been part of health professionals' daily practices and migrants were soon portrayed as 'exotic'. They were also blamed for not understanding the medical messages. The dominant discourse was that migrants had to change and adapt to the kind of care available. Assimilation was the prevalent philosophy. According to care providers, language differences and migrants' 'culture' constituted the main impairments to appropriate care, especially in mental health care. 'Cultural knowledge' was viewed as the tool necessary to allow health professionals to do their job. So, handbooks on 'cultural illnesses' were published, interpreters were hired and special health care services for migrants were created. However, the components of this 'cultural knowledge package' did not help therapists. Instead, cultural differences became an excuse for the ineffectiveness of care (Van Dijk, 1998). According to Van Dongen (2003) the strong emphasis put on 'culture' during this period has not been discarded until this day and is still used to characterise migrants as the 'other'.

In the 1980s, the government acknowledged migrants as permanent settlers and a shift towards a multiculturalist policy took place. The motto was that health care had to be accessible for migrants. The problems encountered in care assistance were no longer attributed to migrants but to health care itself. Although this attitude did not give place to the creation of new services it nevertheless stimulated the promotion of expertise among health professionals. Strong emphasis was put into the fact that care providers had to become culturally sensitive. They had to be able to decipher the migrants' encoded messages and to assist their patients adequately. However, no definition of what 'being sensitive' means or how to do it was provided. Perhaps this major flaw motivated the notable changes introduced on the 1990s. The arrival of a great number of refugees from many different countries during that decade led to the realization that it was impossible to have a 'tool kit of cultural knowledge' for every group (Van Dongen, 2003). Policy makers and health care managers understood that promoting health care professionals' expertise or introducing new facilities was simply not enough. Health care

needed to change structurally towards demand-oriented care. Assistance to migrants thus fell into the scope of intercultural care management (Ingleby, 2003a). This implied changes towards the flexibility, innovation and diversification of the kind of care provided. The end result was the creation of special care programmes and specific care facilities and the introduction of new kinds of intermediate personnel on the health care system. Among these intermediates were interpreters, consultants and 'bicultural' workers. Their task was to advise and facilitate contact between migrants and care professionals. Migrants stopped being seen as a problem and instead became a challenge. As in the 1980s, the multiculturalist philosophy prevailed but now it was further accompanied of concerns with high quality and well managed care for everybody, regardless of cultural or ethnic backgrounds. All together, these developments reflect the process known by interculturalisation of health care.

With the new millennium health care provision is again experiencing a shift that relates to a turn around on the wider political spectrum. Politicians and policy makers argue that the efforts for the integration of migrants have failed. Implicit within the dominant political discourse is the question of whether migrants are willing to integrate. However, integration no longer means acceptance of diversity and equity between cultures but rather 'a step into modernity'. Migrants' culture is portrayed as pre-modern, traditional and backwards, appearing, therefore, in sharp contrast with the modern Dutch culture. Thus, the true question seems to be whether migrants are willing to modernize. Concerning health care, this implies that migrants are expected to become emancipated users. Health policy stresses that health care must be managed in order for a good product to be provided. Health has become in this way a commodity to be acquired at the health care 'market'. The principle of demand-oriented help has not been lost but care is to be tailored according to the needs of those who demand for it. Migrants are thus expected to become committed consumers and active investors on the provision of care and this implies taking responsibility in making care accessible (Van Dijk, 2003). This leads us to two questions: How much care is accessible to migrants? And what must be done to improve accessibility?

The shifts operated on national health policy concerning health care for migrants could lead one to believe that an evidence-based account of migrants' access to care is available. At the same time, if the current health policy requires migrants to actively intervene in making care more accessible guidelines for action should be available. Yet, similarly to what happens with research on migrants' health status, studies concerned with access to

care are often fragmented and in need of theoretical reflection (Van Dijk and Van Dongen, 2000). Available research reports on differences on the use of service facilities between migrants and Dutch natives and between migrant groups. Use of preventive care is considerably lower among migrants. When in contact with primary health care migrants tend to present more often psychosocial, psychosomatic and functional disorders (Knipscheer, 2000). A study by Stronks, Ravelli and Reijneveld (2001) shows that Surinamese, Turks and Moroccans make more use of primary care and of prescribed drugs when compared to Dutch natives. Specialised services are less used by Turks and Moroccans. Antilleans on the other hand use hospital services more frequently than any other group but they score the lowest on primary care use. The authors conclude that ethnic background has a role in explaining these patterns of consumption but they provide no insight on how it might determine the use of health care.

Differences on the use of mental health care appear to be even sharper. A study regarding mental health care use in the city of Rotterdam shows that Turks and male Moroccans tend to use services as much as Dutch natives while Surinamese, Antilleans and Cape Verdeans and Moroccan women make insufficient use of the same services (Dieperink and Wierdsma, 2000). Another study concludes that migrants are more often admitted to intramural community mental health care (CMHC) under a legal order and are also more often re-admitted than Dutch natives. Furthermore, there is an over-representation of migrants in outpatient CMHC within the Randstad[16] while outside the Randstad there is a slight under-representation (De Jong, 1996 in Knipscheer, 2000).

Migrants are generally reported to over-consume somatic care while underconsuming mental health care. But why does this happen? Several barriers have been noted to hinder migrants' health care use. There seems to be a lack of appropriate and accessible information about the health care services available and what those services are able to offer (Lamers, 1992; Kandhai, 1992 in Knipscheer, 2000). Furthermore, studies conducted overseas show that migrants tend to rely on themselves when it comes to distress because they have little confidence on the ability of health professionals to understand and meet their needs (Fatimilehin and Coleman, 1999). Van Dongen and Tankink (2000) also stress this point arguing that the lack of attention of some of the Dutch health professionals towards migrants' explanatory models and perceptions of illness might lead to misunderstandings

16. The Randstad includes the provinces of North Holland, South Holland and Utrecht.

which make migrants feel excluded from health care services. In addition, difficulties concerning language put migrants at greater risk for ineffective communication with their doctors (Van Dijk, 1998).

So far, no evidence able to provide insight on how these barriers might influence migrants' access to care was found. In general, social scientists agree that migrants have poorer access to health care and especially to mental health care (Ingleby, 2003a; Van Dijk, 2003; Van Dongen, 2003). Yet how accessible is health care for migrants at this point in time cannot be said (Van Dijk, 2003). This calls attention to the extreme need for in-depth and evidence-based studies that can bridge the gap and provide reliable information. An article published on the national newspaper Volkskrant proves this need. Based on a report by ZonMv, it was stated that migrants experience good access to health care (Volkskrant, 06/11/2003). This news soon led to a reaction from social scientists and health care professionals[17]. They argued that although the report by ZonMv was based on a considerable number of studies those studies had not yet been completed and this is a problematic much too complex to be approached without solid results. A few days later the Volkskrant published an article by the medical anthropologist Rob van Dijk stating the need for more research and the great deal of uncertainty and lack of knowledge concerning the accessibility of health care services for migrants (Volkskrant, 08/11/2003).

An attempt to set forward some strategies which might assist to the improvement of migrants' access to health care is provided in the last chapter.

2.4 The case of Cape Verdean immigrants – what use of health care?

As discussed above, scarce research and the limitations encountered on the studies concerned with the health of migrants pose great difficulties to a clear-cut account of migrants' health status in the Netherlands. This situation applies to even a greater extent to the case of Cape Verdean immigrants. Few data exists concerning Cape Verdeans' health experiences. Furthermore, no evidence was found of studies carried out at a national level which include Cape Verdeans. Perhaps this so happens because Cape Ver-

17. This information has been provided on an informal basis. Among the organisations and social scientists that subscribed the document are: GGZ Nederland, FORUM, Nederlands Centrum Buitenlanders, Landelijk Bureau, Racismebestrijding, MIKADO, MEX-IT Intercultureel Management, Stichting Pharos, Stichting TANS, Stichting NIJM, Mental Health Center Beeklaan, Stichting Pandora, TPO (Transcultural Psychosocial Organisation), Stichting IGGZ, Bureau Bredeweg, Dwarsverband Interculturalisatie TRIMBOS-instituut, Prof. Dr. D. Ingleby (Universiteit Utrecht), Prof. Dr. J. De Jong (Vrij Universiteit). This document has not been published.

deans form a rather small and concentrated community of little numerical significance and visibility when compared with the main migrant groups. Or perhaps this situation is a consequence of the fact that only in recent years did Cape Verdeans become part of the national policy for ethnic minorities.

Reports on Cape Verdeans' health and use of health care have nevertheless been produced at a local level. In the region of Rotterdam, where Cape Verdean immigrants constitute a more visible minority, research sponsored by the public health authority has also included them as a target group. The following table provides the results of a study comparing for migrants' self-perceived health and psychosocial problems on the basis of the situation for Dutch natives.

Table 3. Deviance mean of experienced health and psychosocial problems for migrant groups in Rotterdam

	Dutch	Turkish	Moroccan	Dutch Caribbean	Surina-mese	Mediter-ranean	Cape Verdean
Experienced Health	1.00	.61	.77	.89	.86	.81	.81
Psychosocial Problems	1.00	1.54	1.32	1.22	1.45	1.61	1.19

Source: Huiskamp et al. (2000).

Like other migrant groups Cape Verdeans' experience a lower health status when compared to Dutch natives. They also experience more psychosocial problems than the autochthonous population. Yet Cape Verdeans (1,19) present less psychosocial problems than any other ethnic minority. Mediterranean (1,61) and Turkish migrants (1,54) score the highest on self-perceived psychosocial problems. Explaining why these differences take place is a difficult task. Only one epidemiological study including Cape Verdean immigrants was found. Resembling the trend of other studies concerned with migrants' mental health, the study focus exclusively on the prevalence rates of (treated) schizophrenia among migrant clients at the out-patient mental health care services in Rotterdam (Schrier *et al*, 2001). The study population is composed by a limited number of Cape Verdean participants - four males and eight females. It is concluded that Cape Verdean women are two to three times more likely to have a schizophrenia diagnosis than Dutch natives. No differences between male Cape Verdeans and Dutch natives were found. These results are not accompanied by further information

on the variables determining the differences encountered. It is just mentioned that the results are in accordance with the findings of British reports on increased frequency of schizophrenia among West-African immigrants. This evidence should, however, be taken with prudence as little consensus exists concerning the prevalence rates of schizophrenia among immigrants of West-African origin in the United Kingdom (see Littlewood and Lipsedge, 1989). At the same time, there is no available international data on mental health problems among Cape Verdeans which is able to provide further insight on these results (Schrier e*t al.*, 2001; Beijers, 2004).

Despite presenting lower experienced health when compared to Dutch natives (see Table 3), Cape Verdean immigrants consult with the general practitioner only slightly more than autochthonous Dutch and less than any other migrant groups.

Table 4. Relative frequency of consultations with general practitioners in Rotterdam

	Dutch	Turkish	Moroccan	Dutch Caribbean	Surina-mese	Mediter-ranean	Cape Verdean
Consulting General Practitioner	1.00	1.86	1.59	1.51	1.27	1.27	1.03

Source: Huiskamp et al. (2000).

Furthermore, Cape Verdeans reportedly underuse mental health care regardless the presence of psychosocial problems. In fact, when compared to other ethnic groups Cape Verdeans have the lowest rates of use of mental health services. Data by the Rotterdam Psychiatric Case Register show that Cape Verdeans have used this sort of services over two times less than Dutch natives, Turks and Moroccans (Dieperink et al., 2002). This data is compiled in the following table.

Table 5. Use of mental health care services in Rotterdam*

		Dutch	Turkish	Moroccan	Surinamese	Dutch Caribbean	Cape Verdean
1990	Males	25.2	30.6	41.2	18.5	14.2	7.1
	Females	35.2	37.4	16.5	18.7	9.8	9.5
	Total	29.7	33.1	30.7	18.4	11.8	8.1
1998	Males	30	31.3	43.2	21.7	16.7	8.9
	Females	46.1	47	32	29.7	18.8	22.6
	Total	36	36.7	36.2	24.6	16.9	15.1

* Annual figures per 1000 for the adult population between 20 and 64 years old.
Source: Dieperink et al (2002).

The figures indicate a significant increase on the use of mental health care services by Cape Verdeans between 1990 and 1998. Yet a closer look makes it evident that this growth is unevenly distributed according to gender. While in 1990 there was only a slight difference on the use of mental health care between Cape Verdean males and females in 1998 females consulted with mental health professionals two and half times more than males. With the exception of Moroccan migrants, in all the other ethnic groups females tend to use mental health care services more than males. However, none of those groups shows such sharp differences as those identified among Cape Verdeans. A possible explanation can be provided with basis on the differences found regarding the use of general health care reported for Cape Verdean immigrants in Portugal. According to França, illness is experienced in a substantially different way by Cape Verdean women and men. While men perceive themselves ill when they can no longer get out of beds and work, women tend to react to lighter symptoms such as headaches, weight variations, etc (1992: 83). Additionally, even though Cape Verdean women tend to self-medicate more often than men at an early stage of illness they visit the general practitioner more frequently. The same situation seems to apply to the case of Cape Verdean immigrants in the Netherlands. According to Sofia Rocha, coordinator of Apoio-project, "if help is needed women are the first to make an effort to get it. They do this for themselves, for their children but also for the men in their families. It is very common to have women seeking help for their husbands, partners, brothers, fathers, uncles, and cousins (...) when a man asks for help is in fact because he is in deep need for it". If women contact more often with the GP they will be more likely to be referred for mental health professionals than men, when the need for it exists. This explanation is however insufficient to account for the generalised underuse of mental health care services among Cape Verdeans.

There are several possible reasons by which Cape Verdean immigrants in the Netherlands might not be using mental health care services. First, despite the stated existence of psychosocial problems among Cape Verdeans they might enjoy better mental health than the general population. It should be borne in mind that the available studies only account for a sample of the population in Rotterdam.

Second, as part of a tightly-knit community which relies on solidarity and a strong social networks, Cape Verdeans may not experience the need to take their problems outside the community, or might even feel pressure not to do so. Regarding this last aspect, several of my key-informants as well as some of my informants stated that some people do not seek for help out of fear of becoming a target for gossip in the community. This fear seems to increase when the problems relate to mental illness.

Third, Cape Verdeans might benefit from their own circuit of healers and care takers. Beijers (2004) states the importance of religion, sects and philosophical doctrines in Cape Verdeans' help-seeking process and the value of healers who are simultaneously able to provide medical care and spiritual guidance. This is the case of a Brazilian credited doctor based in Paris who is at the same time a clairvoyant. The author reports that this doctor is often visited by Cape Verdeans living in the Netherlands and in other European countries.

Apart from France, Cape Verdean immigrants in the Netherlands also consult with mental health specialists and general practitioners in Portugal and Cape Verde (see de Ruuk, 2002; Beijers, 2004). This fact might help to explain why Cape Verdeans consult less with general practitioners when compared to other migrant groups and to Dutch natives. Some of the informants of this study stated that they often seize the opportunity of vacation in those countries to visit doctors. These visits might be further enhanced by Cape Verdean immigrants' networks of relatives and friends in other countries which provide them with information about the health care available but also the support and assistance to access that care. This transnational feature of Cape Verdean migration (Meintel, 2002) might constitute a fourth explanation for Cape Verdeans' low use of mental health care. Relying on connections with several countries and health care systems may prove beneficial at least at two levels. On the one hand seeking for care abroad prevents the danger of gossip within the community as, for instance, one is less likely to meet with an acquaintance on the way to the doctor. On the other hand, it favours communication in a familiar language like Portuguese or the native language Kriol.

Finally, Cape Verdeans might be making few use of mental health care because they find it inaccessible. This can be related to different sorts of barriers such as the lack of information concerning the services available, difficulties encountered on the first line of care which undermine referrals to specialists, communication problems or different expectations regarding care provision and, ultimately, treatment.

Cape Verdeans are described as a rather active community with great involvement on the creation of all sorts of associations (França, 1992; Saint-Maurice, 1997; de Gruyter, 2003: Da Graça, 2005). In the Netherlands, many of those associations are connected to leisure activities such as sports and music but there are also an increasing number of projects focusing on social care and dissemination of information regarding health and health care services. Apoio-project and Nôs Saúde are two such examples. Nôs Saúde is a project developed by the Verwey-Jonker Instituut in collaboration with the Avanço-Foundation, the umbrella organisation for Cape Verdean associations in Rotterdam. This project focused on the creation of in-depth portraits of the health stories of Cape Verdean immigrant women in Rotterdam. It also put attention to the informal and formal social infrastructure available for the community. The ultimate goal of the project consisted of using the information attained to develop interventions on the field of health. Those interventions will be developed with the joint collaboration of municipal leaders and health care professionals (de Gruyter, 2003).

Apoio-project is a community-based and advocacy project initiated by Basisberaad GGZ, the advocacy and empowerment organization for mental health care clients in Rotterdam, and Avanço Foundation. The project began by assigning an independent Cape Verdean social worker with the goal of alleviating the existent gap between Cape Verdeans and mental health care. Nowadays, it accounts with the collaboration of several volunteers and peer-support groups. The project aims at providing information to the community, advising and helping Cape Verdeans to access mental health care. It advocates for changes in mental health care delivery towards the needs of Cape Verdeans (Smulders, 2003). These are both recent projects initiated in 2002 whose results are awaited with great expectations. In the meanwhile, one way by which the question of the underuse of mental health care can be approached is by focusing on Cape Verdeans' perceptions of health care professionals. As mentioned above, general practitioners hold a key-function as gatekeepers to the health care system and they have an essential role in creating the necessary conditions for users to access care. The next chapter attempts to bring some insight on how doctor-patient interactions might be influenced by health care philosophies.

3

RELATIONSHIPS BETWEEN PATIENTS AND DOCTORS

Shifts operated on health care policy in the Netherlands towards the implementation of a model of managed health care have led to a redefinition of the roles awarded to the different parties involved on care provision. This chapter focuses on how these shifts might be influencing the relationship between doctors and patients. Attention is also put to the philosophies prevalent within Dutch health care and how they might be contributing to create a distinction between 'good' and 'bad' patients. Finally, a list of key-characteristics is provided in accordance to what defines a 'good doctor'.

3.1 The doctor-patient relationship

The doctor-patient relationship consists of three main elements: manner, information transfer and decision-making including responsibility (Buetow, 1995). Available research suggests that patients' compliance with medical regimens is related to the kind of doctor-patient interaction. It has been observed that compliance is higher when physicians give explicit and appropriate instructions and more and better feedback (Garrity, 1981). It has also been noted that non-compliance increases when patients' expectations are not met or their physicians are not behaving in a friendly manner (Korsch *et al.*, 1969 in Conrad, 1985). Thus, the doctor's tone of voice, the words chosen, the way he or she examines, touches and looks at the patient are all central to how the patients 'feels' during and after the medical encounter (Lupton, 1997). Both the majority of patients and doctors favour friendliness, sensitivity, concern, respect and listening skills as important aspects of the doctor's interpersonal manner and attitude (Buetow, 1995). It is not certain however how much information doctors and patients want for themselves or are willing to share with each other. While some patients gladly promote and receive information concerning their health problems other patients avoid that information, especially if it might have negative connotations. Nevertheless, both doctors and patients agree on the importance of sharing information about illness and health and the effects, risks and alternatives of treatment for an active participation of the patient on decision-making and treatment (Buetow, 1995).

As described on the previous chapter there has been a tendency within Dutch national health policy to change health care delivery towards a model of managed health care. In this sense, medical services are to be treated as

any other commodity that can be effectively produced and consumed under competitive market conditions (Logan, 1989 in Lupton, 1997). According to Lupton (1997) those who adopt this model view doctors as simply suppliers of services, competing amongst themselves and seeking to maximize their income by selling their professional expertise. Should the market flourish users will benefit from a wide range of services and professionals willing to provide the best 'commodity'. Yet, this approach implies that patients will be treated as consumers able to actively evaluate doctor's services and seek for care elsewhere should they be displeased with the 'commodity' attained. In other words, patients are perceived as dispassionate, thinking and calculating subjects who have full knowledge of the available services and complete sovereignty when making the choice of which services to use. Based on a study conducted with Australian patients Lupton (1997) argues that such a representation of patients fails to recognise the often unconscious and unarticulated dependency that patients may have on doctors. While in some situations people opt for an active role on the decision of the kind of treatment they wish to have the same people might on other occasions adopt a position as 'passive patients' investing their trust and faith on health professionals and leaving decisions to them. Thus, even if a model of managed care is implemented that must not mean that all patients will embrace a 'consumer' behaviour.

In order to better understand what Cape Verdean immigrants expect and perceive to be a good doctor it is important to provide some insight on the sort of philosophies prevalent within the Dutch health care system and the way it influences the doctor-patient relationship. The following section focuses on these matters. It should be borne in mind that these are preliminary observations since no published information was found. The tentative conclusions presented next derive from an interview with Martijn Kole, a staff member from the user-support organisation Client Raad, and informal talks with Huub Beijers and David Ingleby, two social scientists concerned with issues relating to migrants and the use of mental health care.

3.1.1 Philosophies within the Dutch health care system

According to Young medical belief systems are "sets of premises and ideas which enable people to organise their perceptions and experiences of medical events and to organise their interventions for affecting and controlling these events" (1983: 1205). These systems can be better understood if put within a continuum between two extremes: the internalising and the externalising systems. The externalising systems focus on the aetiologies, i.e.

identifying the agents, motives and extra-somatic circumstances which lead to the onset of the symptoms. On the other hand, the internalising systems focus on intra-somatic events, explaining sickness and curing through ideas about physiological and pathophysiological processes. Thus, while internalising systems are concerned with identifying and organising symptoms into diagnoses the externalising systems seek for the social events and circumstances that preceded the onset of symptoms producing narrative accounts of illness. Modern medicine falls widely within the internalising extreme (Young, 1983). The same seems to apply to Dutch medicine to a certain extent.

In Dutch medical practice there is a fairly strong emphasis on avoiding unnecessary medicalization of problems. GPs are aware that most of the complaints presented to them tend to disappear after a certain time, whether or not they are treated. There is also concern to reduce the level of iatrogenic illnesses. Directives for future practice stress the prevention of medically-caused illnesses instructing practitioners to adopt an attitude of 'watchful waiting' (NGH and LHV, 2002). In practice, this means that doctors look and observe before diagnosing and treating, often sending patients home with a prescription for analgesics and advising them to return in case the symptoms persist.

When the need for specialised care is identified and the probability that the health condition might improve through the help of specialists is high patients are referred to the second line of care. According to Martijn Kole, specialists in the Netherlands are trained to produce diagnoses as rapidly and efficiently as possible. Furthermore, they are encouraged to always seek for the ultimate and most effective solution for health problems. This links to the fact that the Dutch society has for a long time been accustomed to high life standards and values knowledge as an important factor for development. A general prevalent idea is that once the means are accessible everything can be accomplishable. Thus, provided that doctors get good training and knowledge and that medical means are available they shall be able to heal patients. In this sense, failure on diagnosing or on the treatment is seen as a taboo. In addition, the influence of health sponsors and of managers on care provision has increased substantially in the last decades. These agencies have put considerable pressure into the provision of effective low cost care and the minimization of practices which might make use of resources with no concrete results. This situation stimulates competition between health providers in the attempt to offer the best product at the lower cost and in that way target for the best sponsors and insurance companies. This tendency is particularly salient on a report by the National Institute for Public Health

and the Environment (RIVM) which states that care providers must not only be professional care-takers but also entrepreneurs (Van der Oers, 2003). In this way, the interaction between specialists and patients is pushed into a business-like sort of relationship. This type of relationship is often based on one-way type of communication (from the doctor to the patient), leaving few room to explain the meaning of the technical terminology employed and the sort of treatment to be used and to accompany the patient on a emotional level during the healing process. The same situation applies to general practitioners although in a slightly different way.

As noted on the previous chapter, in order to access health care services patients are required to have a referral letter from their GP. In practical terms this means that all health care users must pass through the general practitioner's office every time they need to consult with a different professional or service. General practitioners hold thus a key position in the health care system. They are both the 'face' and the 'filter' of the system. They are the first to be consulted and the ones to decide if patients need more care and where they can get it. Yet, because general practitioners have been given a gatekeeper function they are also expected to make efficient diagnoses and provide effective treatments as to prevent unnecessary overloads of the specialised services. In other words, they are expected to provide care as much as their medical competencies allow for and only in situations in which the diagnosis demands for further observation or treatment refer patients to specialised care. This sort of expectations has grown on the past years also as a consequence of the increasing role of insurance companies on the management of the health care system. Unsuccessful treatments might have dramatic consequences for the patients. Furthermore, they are at least twice as expensive because there is a need for a second trial and in such circumstances both technical and personnel resources are overused reducing their availability to other patients. In order to stimulate an economically viable health system misdiagnosis and the possibility of failed treatments must be decreased. One way to do so is by 'filtering' the sort of patients that arrive to specialised care or rather, to make sure that the patients sent to secondary care are likely to have a health condition which has high probabilities of recovery after care is provided. This situation is compelling general practitioners to produce non-doubtful and fast diagnoses but also to seek out solutions within their own practices for those patients' whose problems are not suited for specialised care. However, these expectations are becoming harder to satisfy. In the Netherlands, there is a consistent and widespread lack of general practitioners (OECD, 2000). These doctors' schedules are often overloaded forcing them to reduce the time of consultations. The

average time for consultation hardly ever exceeds ten minutes. Furthermore, although GPs deliver health care to 96 per cent of all care users, only 4 per cent of the funding is allocated to the first line of care. From the total amount of users who visit GPs only 2,5 per cent are referred for second line care (Cardol *et al.*, 2004).

A consultation as short as the described above confronts patients with a demand for a clear view of the symptoms experienced and good ability to put those symptoms into understandable accounts of the illness. At the same time, while promoting demand-oriented care national health policy stresses the importance of service users in making care suitable to their needs. Users are expected to be better informed, more emancipated and to act as an actual consumer (Van der Oers, 2003). This means that patients must know more about the sort of services available, they must demand for the type of care that best suits them and they must make sure to select the best service available. This image of patients brings us back to the 'consumerist' type of patient behaviour described in the section above, i.e. a dispassionate, thinking and calculating patient with full capacities to move through the intricate system of health care. Moreover, it exposes health as a commodity whose attainment and provision must be negotiated by the different parties involved: providers, users and insurers. Hence, patients must be able to prove their problems serious enough to target the attention of their GPs and worth a referral for a specialist when necessary. In this way, help becomes conditional. Relationships between GPs and patients tend to be business-like, almost methodical events. This type of relationships are likely to be challenging for patients who experience not only physical but also mental distress and who are less acquainted with the health care system and the sort of care provision available. Two of the participants of this study explained that before they were diagnosed depression they did not acknowledge sleeplessness and forgetfulness as symptoms of that condition. They felt that something was wrong but they could not guess what it was or which sort of care they needed. Only after repeated complains to their general practitioners were they referred to a psychologist. These two patients were arguably in a vulnerable position because they do not correspond to the ideal type of a 'consumer' patient.

3.1.2 Good and bad patients

As I attempted to show above, changes on Dutch health care policy have had an impact on the roles attributed to professionals and users. In regard to users two different categories appear to have emerged as a consequence

of the ability to satisfy these expectations: on the one hand, there are users who are able to adapt and respond to the demands of the health system; on the other, there are users who are unable or unwilling to do so. I will term these categories as 'good' and 'bad' patients.

Current developments within national health policy demand for progressive maximization of resources and greater pressure is put on health care professionals to comply with that policy. Patients are also expected to participate actively on promoting care adapted to their needs. They are expected to behave in a way which allows for an effective care provision at lower costs. The good patient will thus be someone informed about the available services, who knows how to expose his or her problems and who is willing to abide by the decision regarding the sort of treatment necessary. This picture will be further completed if the solution for the patients' problem is evident and has a high probability of success and if the patient agrees to comply with the doctor's orientations. On the other hand, a patient who has several problems and is not able to provide a thorough explanation of what he or she feels might be considered a bad patient. By presenting a vague complain the patient will need further attention from his or her doctor. Yet because health insurers exert pressure to get doctors to target for good patients it is likely that vague patients with non-identifiable and unappealing problems will be given vague treatments. The prescription of the analgesic Paracetamol can be used as a metaphor for this sort of treatments.

While good patients are likely to fully benefit from the health care system bad patients see the quality of their care challenged by their inability to adjust to the system. This condition might in turn be a consequence of the lack of information regarding the expectations that lie on them which further undermines their access to care.

But how must health professionals behave according to patients? The following provides a key-list of attributes used to characterise a 'good doctor'.

3.2 The good doctor

Included on the debate regarding the efficacy and accessibility of care should be what users consider to be a good health professional. No literature on this subject was found in respect to the Netherlands. Furthermore, no data was found regarding users' perspectives on the matter. As an effort to implement a Primary Care Trust Clinical Governance Strategy in the United Kingdom a group of care providers discussed this issue. The health professionals attai-

ned the following list of 'key qualities' necessary to care providers according to a users' perspective:

- Approachable.
- Non-discriminatory and non-judgemental.
- Be aware of up-to-date information.
- Confidence.
- Sensitivity/ confidentiality.
- Honesty/ trustworthy.
- Work in patient partnerships is appropriate.
- Good follow-up.
- Recognising limitations.
- Good relationship.
- Empathetic/ sympathetic/ giving undivided attention during consultations.
- Efficient in terms of documents and referrals/ good systems.
- Possess good communication skills in terms of listening, language used and to be culturally sensitive.
- Accessible in terms of consultation time/duration, visiting, telephone advice/ availability.
- Clinical expertise/ competent – both clinically and with inter-personal skills.

(Edgar, 2002)

It is the goal of this study to gain understanding of Cape Verdeans' perceptions of what a good health provider is. This list has served as a starting point for the analysis that follows on the next chapter.

4

SEEKING THE GOOD DOCTOR

4.1 Results of the study

During the interviews it quickly became clear that most of participants' experiences with health professionals occurred at the level of primary care. Within the first line of care, the general practitioner was the most consulted professional[18]. It was also noticeable that most participants knew little about mental health care services, how they were provided and how to gain access to them. In the cases where participants held contact with mental health professionals no relevant distinctions were made between care experiences with psychologists and psychiatrists. For this reason the data concerning experiences with these professionals is presented under a single category, i.e. mental health professionals.

In this section are presented the main themes derived from the data and some preliminary discussion of the matters at stake. The themes are presented in relation to four topics: expectations concerning the performance of health care professionals, perceptions of health care professionals, transnational health care seeking and the 'good doctor'.

4.1.1 Expectations concerning the performance of health care professionals

Unconditional help

One of the most recurrent themes in the interviews was the need for prompt and unconditional help. This theme was particularly associated with expectations concerning health care professionals. In many cases, the lack of immediate and unrestricted health care was unexpected and faced with dissatisfaction.

All participants had experiences with health care systems outside the Netherlands. Besides the use of health care in Cape Verde, several participants had contact with health care professionals in other countries such as Portugal, France, Guinea and Italy. These contacts took place either during visits to relatives or friends living in those countries or because participants lived there themselves before they came to the Netherlands.

18. Participants often refer to these professionals as 'family doctor' or 'house doctor'. In Portuguese the correspondent terms are *médico de família* and *médico de casa*. The last term might be a direct translation from the Dutch *huisarts*.

> *'I came to the Netherlands from Portugal. I was living there since 1974. My children are all born there. We came to the Netherlands in 1992 but my husband has been working here as a seaman since 1970 ... I was born in Sal but I was raised with my grandmother in Santo Nicolau, my husband's island. My mother lived in Portugal. She lived in Portugal all these years and I was always with my grandmother. In 1970 I went to Italy and lived there for a bit more than three years. Then in 1974 I went to Portugal to have my daughter. I had her in Santa Maria hospital". (Judite)*

In general, participants looked into their experiences with health care providers in Cape Verde or in previous migration countries when describing their expectations of health professionals in the Netherlands.

> *When I arrived to the Netherlands I thought the doctors were going to be the same as in Portugal or France. Then I got disappointed when I saw that was not the case. The system here is different than there. Here they wait too long to treat people. (Dulce)*

One of the differences encountered was that effective treatment was not readily provided. In some cases, participants felt their doctors did not spent time enough with them to make possible a detailed examination. They were often sent home with just a prescription for analgesics such as Paracetamol. This sort of 'treatment' is also described by Mexican immigrants (Pylpa, 2001) and Brazilian immigrant women (Messias, 2002) in the United States.

> *When I go there [health centre] I only last ten minutes in the doctor's room. He doesn't check my blood and my heart. He doesn't examine my body to see how I am doing. He only looks and listens to what I say, gives me my usual medication for Lupus and if I say I have some sort of a pain he gives me Paracetamol. That is all. (Paula)*

The prescription of Paracetamol often emerged in the interviews as a metaphor for non-attentive, disinterested and ineffective treatment:

> *They [health care providers] are less interested in the patient and the treatments are not so effective. Here they give a general treatment for everyone. They prescribe Paracetamol for everything and not everyone needs that. (Dulce)*

Yet, increasing experience with health care providers lead some participants to realize that the generalised, dismissive and inappropriate 'Paracetamol treatment' could be replaced by a specific, satisfactory and appropriate treatment. This could be attained provided their ability to make understandable the 'genuineness' of their health care needs. Many of the participants felt in fact that they had to convince care providers of their need for help:

> *The first times I went to the doctor I have now he was difficult. Even when my children needed exams... In Portugal if you feel something the doctors send you immediately to a specialist. Here you need to go to the doctor several times and talk to him very seriously and explain that you are not feeling well. (Judite)*

Paula felt concerned with this situation and explained why it is necessary to prove the need for health care:

> *Perhaps many of the doctors think we go there to ask for attention. Maybe they think that we don't have anything but we feel lonely and in need for attention. So sometimes they don't give importance to what people tell them. I didn't experience this myself but there are people who go to the doctor and he or she sends those people home with no real examination and in the next day the person dies. I think they don't pay enough attention to people.*

Dulce saw things differently:

> *I think the Dutch doctors... well, all doctors... all doctors work to earn money but the Dutch seem to be there more to have the patient marking his or her presence... or so I think... more to have a certain number of people they see per day. So they don't show interest. They don't give the patient the attention he or she deserves. (...) I think the reason why they don't prescribe other sorts of medication has to do with the economy of the country. I think they don't want to invest in medication so they take the cheapest option. And I think the cheapest option is to prescribe Paracetamol.*

In general, participants agreed that if they wanted more than Paracetamol they had to be careful with the way by which they explained their problems to health professionals:

> *I think it has to do with the way the problem is explained to the doctor. If the problem isn't clear the doctor doesn't send the person to a specialist. So, the doctor gives Paracetamol and that is it. (Joana)*

4.1.2 Perceptions concerning the performance of health care professionals

Relationship with the general practitioner

Issues concerning the relationship with the general practitioner (GP) emerged several times in all interviews. This was expected given the key-role of GPs as gatekeepers of the health care system. More than half of the participants described their relationship with their GP as problematic. The short time awarded per consultation was one of the matters that most struck the participants, at first causing surprise and later discontent.

> *Here a visit to the doctor doesn't take longer than ten minutes. In Portugal it takes the time that is necessary. This is why I say that the doctors show no interest on the patients. It is impossible to examine the human body in ten minutes. The patient needs at least ten minutes to explain the problem. To make the examination at least ten minutes more are necessary. It is impossible for the patient to talk, the doctor to make questions, diagnose and prescribe medication if necessary in only ten minutes. (Dulce)*

The limitation of time on consultations with GPs appears to have intensified in the last years. Some participants were able to conform and adapt to this situation. Others felt considerably vulnerable and disregarded. Due to lack of time and pressure to end the consultation, Paula experienced considerable difficulties in explaining the purpose of her visit:

> *I think now they are different than before because they have less time. Now it is all done in a rush... sometimes I can't remember anymore what I went to say. It is gone. I think there are many things that changed here. I don't know... maybe it's because there are more people or more stress... I don't know.*

Another participant told how these short consultations impacted on her care:

> *Before, when I first got ill in the Netherlands the doctor that took care of me did everything. If I complained of my stomach he listened to my heart, had me weighed, got my pulse. Now it is all done in a rush. Sometimes he even forgets things (Judite)*

Dulce explained why she believed consultations were kept so brief and how this conditioned GPs' behaviour towards users:

> *I think that here in The Netherlands they [GPs] must have a big list of patients to see per day and because of that they have limited time for each patient. I noticed that when I'm at the doctor's office and our time is reaching ten minutes, if I'm still making questions he gets irritated. Then, they don't want to answer the patients' questions and it seems like they want to throw us out of their door. They should give us more time and attention.*

Two other participants explained that relationships with GPs were difficult due to lack of attention by the GP. This situation undermined access to information and, ultimately, to health care. In Paula's case, Sofia Rocha, the coordinator of Apoio-project was a key-element in facilitating her use of mental health care. This pathway to health care shows that help is many times accidental.

> *Sometimes doctors have a personal character that doesn't go along well with our own. Sometimes people say they go to the doctor and he doesn't even look at them, he doesn't speak to them. As soon as they [patients] get there [GPs' office] they [GPs] immediately start writing the medication prescription. It's very important that health professionals are thoughtful, that they pay attention. Otherwise, people don't feel comfortable and can't get the right information. Then problems are prolonged because they don't know where to go to get help. (Joana)*

> *I went to the psychiatrist because Sofia [Sofia Rocha] sent me there. I think it's not difficult to go where they help but you must know the way. My family doctor didn't send me to the psychiatrist. She got me to exchange letters with other people who had problems but that didn't help because I didn't see the people. Then I heard Sofia on the radio talking about depression, schizophrenia and other things. I called her and went to see her. It was all for free and that's very good. Sofia realized the problem wasn't for her and sent me to the psychiatrist. (Paula)*

Participants expressed the wish to have an attentive doctor, able to keep awareness of their conditions, but who was also directive and determined when proposing treatments and who took the lead during consultations:

I think it's not necessary to explain the whole problem to the doctor every time we go there. She knows me and she knows what I need. I shouldn't have to say, 'Doctor, check my pressure. Doctor, check my lungs'. I would like to be more supervised. The doctor is the one who knows. He should make the questions and then tell me what the best treatment is. (Paula)

If I have pain in my arm I shouldn't have to be the one saying to the doctor, 'I have to do an X-ray'. They [GPs] are the ones who studied. So they must make questions to the patient and then see what the problem is. The patient shouldn't be the one saying what he/she needs. (Dulce)

Some participants felt diagnoses were not always accurate and information about their health conditions was not promptly and entirely shared with them. These circumstances hindered their trust on GPs. Some participants viewed consultation with health providers outside the Netherlands as the only means to be certified of their 'true' state of health:

I would like to go to Portugal because I don't trust the doctor here. I want to be examined there. (...) A lot of people say that here they tell you that nothing is wrong but when you go there [Portugal] you find things. If we go there they tell you when you have a problem. (Marta)

Other participants suggested different strategies to get appropriate health care. While some believed it was necessary to adapt their help-seeking behaviour to that expected by GPs in the Netherlands, insisting to get the care they needed, others would prefer to be granted another GP. However, participants considered the latter option unfeasible given the limited number of GPs in the Netherlands.

I would suggest them to go to the doctor again. I think they must keep trying. They must try until getting what's necessary. It's like when one is studying and fails a year, one must return the year after. People must explain better to the doctor what they feel. They must convince the doctor of what they have. (Manuel)

You must always have a house doctor but if you want to choose your own you can't. If you hear from someone that there is a good doctor and you want to have him or her to be your doctor that's not possible. They have no more vacancies, they are full. (Helena)

Manuel described what a satisfactory relationship with his GP entails:

> *When I have a problem I go to the doctor and talk to him. Then he listens to my heart, he checks my lungs and my blood pressure and then he sees what's needed. If it is necessary he gives me pills if not he doesn't. If I have to go to the specialist he sends me to one. I have had no problems. When I go to my doctor I always have the time I need. Sometimes it's ten minutes sometimes it's twenty-five. Of course we know a doctor can't do miracles but he does what he can and what he must do. He takes care I get the treatment I need.*

Referrals

Most participants felt consultations with specialised health professionals were difficult to obtain. These consultations were dependant on GPs' referrals and were perceived as conditional.

> *Here they don't refer for specialists often. I hear people saying that someone died because the family doctor didn't send the person to the specialist at the right time. I think this has to do with the way the problem is explained to the doctor. If the problem isn't clear the doctor doesn't send the person to a specialist. (Joana)*

Being dependant on GPs' referrals to obtain specialised care made some participants uncomfortable. This situation was particularly critical for participants with chronic illnesses. They felt powerless over their health conditions. Dulce has sickle cell anaemia and she expressed her worries for not being able to bypass GP's referrals and seek specialised care directly:

> *Here I always have to go to the family doctor. I can't decide by myself if I need to go to the specialist. I have to go to the family doctor and then he decides if I go to the specialist or not. I would rather be able to go directly to the specialist because otherwise I loose a lot of time. Also, if he [GP] says, 'No' I can't solve my problem. If I feel the need to go to the specialist and the family doctor says I don't, I go to France and see the specialist there. This way I avoid disagreements with the doctors here. I have no problems in being consulted by a [specialist] doctor there.*

Some participants told also how they heard stories of people in the Cape Verdean community who died because they were treated too late or not got misdiagnosed:

> *Some people complain their doctors do not send them to the specialist. Some people had complained for a long time of headaches and they were never sent to the specialist so they end up dying, even young people. I do not know why they do not send them to the specialist but I heard some people saying that maybe they get benefits if they do not give extra expenses to the state. But I do not know, I never got a confirmation for that. I think a doctor who is not a specialist and has a patient who always complains of headaches must think that is not a normal pain. (Marta)*

Several participants felt they had to negotiate the use of specialised care with GPs. Making a clear statement of the problem was the first step towards the success of the negotiation. The second step consisted of proving the seriousness of the problem and the implied need for care. The third and last step regards the formulation of a request for referral. Judite explained how the negotiation process took place in her case:

> *Here to get a special exam... much has to be said. Unless you have something serious... for example, when I had surgery at the hospital all doctors paid a lot of attention to me. As soon as they found out what I had they told me I had two weeks to make the decision of removing my breast... Now, when I feel something is wrong, even if my house doctor thinks I don't need to see a specialist, he sends me to one just so I feel calmer. They are more careful when they know what problem you have. When they don't know what the problem is they go around the issue... and don't do anything.*

However, Judite is not fully convinced of the accuracy of her GPs' diagnosis and supervision. Again, trust in health providers is put at stake. Judite seeks to have her condition monitored in Portugal every time she can:

> *Every time I go to Portugal I like to visit the doctor. Since I had the problem in my breast I always go. They talk our language there and there are always exams. They tell you what you have and here sometimes they say everything is well. This way I'm sure about what I have. Also, if they [GPs and specialists in Portugal] have any sort of doubts they sent you to do special exams to be sure about the problem.*

Relationship with mental health professionals

Participants' relationship with mental health providers appeared to be influenced by providers' ability to listen and make participants feel comfortable by showing attention, availability and interest. Only one of the four participants who had contact with these professionals sought mental health care out of personal initiative. The other participants came in contact with the services through the help of other professionals.

> *Before I thought people only went to the psychiatrist because they had no notion of life anymore. I never imagined that one day I would need to go to one. Then, after I got in contact with Sofia [Sofia Rocha, project APOIO], I realized that the psychiatrist is not only for people 'out of themselves' but also for people with other kind of problems. Sofia said I should go there, so I did. (Paula)*

Some participants stated that mental problems are highly stigmatised among the Cape Verdean community and that hinders the process of seeking for help:

> *If people say they go to the psychologist others talk in their backs. I think the problem is that Cape Verdeans still haven't accepted it's an illness. (Joana)*

> *They don't seek for help because they have a stigma about mental health. They believe other people will think they are crazy. Some are afraid of talking to a doctor about their private lives. I heard that sometimes people have really serious problems and they end up not being able to go to work. They stay home. (Judite)*

Most participants knew very little about mental health care provision. Joana explained how her initial uncertainty about seeking for mental health care turned into a positive experience of helpful, well-adjusted care:

> *I went to the psychotherapist a year and half ago. At first I didn't want to go but I felt I should. I needed to get order in my thoughts and understand the things that happened in my life. So I went there and I liked it. She wanted me to keep going for a longer time but I felt if I stayed I would never be able to quit. I went there ten times, once a week for forty-five minutes. It helped me a lot. I never had such an experience so everything was new for me but I got used to it just fine. She let me*

> *talk and sometimes asked things. I felt she was there to listen to me and that was very good. I liked the way our talks went. She gave me homework and that was very good because it made me feel calm.*

Paula's relationship with her psychiatrist was problematic. She did not expect to adopt an active position on her treatment and she felt defied when the psychiatrist requested her to do so:

> *They made an evaluation to know if I needed their assistance. A psychiatrist did it. The second time I went there I got a new psychiatrist. She had the results of my evaluation. She looked at me and asked, 'What do you expect from me?' I told her she had the evaluation and that she already knew why I went there. But she asked again, 'What do you expect me to do for you?' I answered it was not up to me to say what I wanted or not. I told her she should study my case to know in what way she could help me. I told her if I knew I had to tell her what I wanted to be done I wouldn't have gone there. If I already knew what I wanted I could help myself.*

Difficulties to comply with the treatment and the use of medication appeared greater when the participants were unable to establish good relationships with their mental health providers:

> *In RIAGG [out-patient mental health service] they said I should take the medicine and then we would see. The psychiatrist should have sent me an invitation to go back but she didn't. I'm also not interested because they only help me with medicine. I don't want to take the medicine because it's bad for me. (Marta)*

> *The psychiatrist told me to do things at home but I don't understand it. She told me to grade with numbers how I feel each day. But I don't understand how I'm supposed to evaluate myself. She says that if I go out with a friend that is a 10 and if I stay home that is a 3 but this makes no sense to me. When I went to talk to her she asked about the homework. I apologised and said I didn't understand well what that of evaluating me was. That evaluation didn't make sense. It was absurd. (Paula)*

Judite stated the importance of building a trustful and secure relationship with her psychologist. She requested other people to join her in the therapy sessions until she was able to benefit of such a relationship. Sofia Rocha

from project APOIO was often mentioned to accompany the participants both to consultations with GPs and mental health care providers.

> *I went to the psychologist with Sofia [Sofia Rocha] the first times. Then my daughter went along with me a couple of times but lately I have been going alone. Now I know the psychologist and he knows me. If I don't understand him I ask and he repeats things.*

4.1.3 Transnational health care seeking

Transnational health resources and practices

Experiencing a state of good health was highly valued by all participants and a goal to be spared no efforts. As observed before, some participants experienced that good quality health care was not readily available in the Netherlands. In some cases, participants adapted their help-seeking behaviour accordingly to the expectations of health care providers. This entailed the formulation of problems according to care providers' understanding and a more active attitude in demanding for the provision of effective treatments. In other cases, participants felt the need to verify and complement the care provided in the Netherlands with use of health care in other European countries. According to Manuel, the pursuit of good health over-spans borders and any potential barriers of language, communication, culture or information:

> *In Cape Verde there are doctors that speak our own language but health has no borders. When a person has a health problem and seeks for help there are no borders. If you know there are good doctors in Switzerland you will go there. If you are in Portugal and you heard there are better doctors in Spain you will go to Spain. When you are searching to have health there are no borders. You go where you have to.*

Other barriers might be harder to overcome. Marta is a single mother living on social welfare due to health problems. Like many other Cape Verdeans she has a low income and a fair amount of debts. She believes the quality of care is better in Portugal even if she has not yet used it. Despite the wish to do so she faces economic and legal constraints:

> *There are doctors in Cape Verde but in Portugal they are better. But what can I do, they don't allow me to leave because of my debts. I don't have much money so I can't pay my debts. I asked support from the*

state and now I can't leave. All Cape Verdeans say that Portuguese doctors are very good.

Meanwhile, Marta incurs on transnational practices of self-medication resorting to medicines prescribed in Portugal. She 'imports' these medicines to the Netherlands through the help of friends. The use of transnational medicines represents Marta's efforts to seek for the best health care available, even if she can only access it indirectly. Yet these practices might bring her into a risk situation. Marta acknowledges that to a certain extent but her idealized image of Portuguese health care remains undisturbed:

A friend of mine had pain in the abdomen. She went to the doctor here and they told her she didn't have anything. She went to Portugal and they found out she had a stomach problem. She had to have surgery. When I had an abortion they said my ovaries weren't well but the doctor here always says I don't have anything. I take these medicines from Portugal and they help me sleep and eat. But if I take a pill today I feel pain in my ovaries tomorrow. No one prescribed me this medicine... but many people take it. Almost all Cape Verdeans use it. It helps you with everything. If you have problems and you are angry, you can take it and you will sleep well. I asked a friend to get it in Portugal. I know it since [the times I lived in] Cape Verde.

Judite, Helena and Dulce often resort to transnational health care in Portugal and France where they migrated to before settling in the Netherlands. Their reliance on medical coverage on those countries laid on positive experiences with its health care services and on the perpetuation of health insurances which granted them full entitlement to care. Additionally, they upheld intense contact with other members of the diaspora and with locals. These contacts reflect the strong presence of transnational ties among Cape Verdean immigrant communities. Many of the participants have friends and relatives in several countries of Europe and in the United States with whom they sustain active contact. When a problem arises they are able to rely on their networks in order to find the best solution. In what concerns health, these personal connections favour not only the access to information concerning the sort of care available but also how to make use of that care. Furthermore, if the decision to go to other country to consult with a doctor is made participants are welcomed and supported by their friends and relatives.

In France I have both a family and a specialist doctor. When I feel I'm about to have a crisis because of my illness [sickle cell anaemia] I go

> *there. Sometimes I don't even go to the doctor here. If I'm well enough I get on a plane and go to the doctor in France. I can make a direct appointment with the specialist there. (...) Sometimes, when I'm on vacation in Portugal I also go to the doctor to check on my condition. (Dulce)*

Transnational health care resources helped Dulce claiming back agency on the management of her illness. Being diagnosed at an early age with a chronic illness has made Dulce an expert on the sort of health care that is best adjusted to deal with her condition. The experience of conditional referrals in the Netherlands concerned Dulce that one day she might just be too late for a visit to the specialist. Dulce relies both on her knowledge of and entitlement to French health care and on her family to make her health care seeking process as effective and comforting as possible. Furthermore, she upholds strong transnational ties of friendship with people in Portugal, visiting them often and also using those opportunities to obtain confirmation and assurance of her state of health. By maximizing these transnational health care resources Dulce is able to bypass the 'Paracetamol treatment' in the Netherlands and directly seek the health care she identifies as appropriate to her needs. However, the trust, familiarity and preference for transnational health care sometimes forced Dulce to postpone consultation with health care providers. This same attitude has been observed among Brazilian immigrant women in the United States (Messias, 2002).

> *I need to do a lot. I need to go to the dentist but I am not doing it here. I am waiting until I can go to France. (...) I still pay for my social security in France and I am entitled to care there. I won't stop paying it because here I can't get the care I need. So I will take my time and take care of health there.*

The use of transnational health care appears common within the Cape Verdean community and it has been documented in other studies (De Ruuk, 2002; Beijers, 2004). According to Joana this is a strategy put in practice to counter the inability to make use of appropriate health care in the Netherlands. Yet it might as well be that some Cape Verdeans are still to find out how to solve the riddle of converting a 'Paracetamol treatment' into an appropriate one.

> *When Cape Verdean people have a problem they go to the doctor but they aren't always able to explain what they have. So people often go to France or to Spain to look for other doctors. Some of them also go to Portugal once a year. I never had to do that.*

4.1.4 The good doctor

Good Doctor

All participants were able to provide an account of what they find a good doctor. Previous experiences with health care providers in other countries proved relevant when explaining what being a good doctor entails:

> *A good doctor is like those doctors in Portugal. Now there are no longer good doctors in Portugal either. A good doctor is someone who receives you with a friendly and joyful face that takes your pulse, measures your blood pressure, looks at the eyes, and looks in your throat. Now they no longer do that. They only do it if you ask for it. They no longer give attention to the person as they use to. When I was younger I did not need to go to the doctor but my grandmother was very ill and I used to go with her [GP in Cape Verde]. When we went to the doctor he treated us by our own name. They look into everything: pulse, eyes, and throat. They gave us attention. Now if you go there and tell them you have not been sleeping well they give you a prescription and say go get the medicine. They see you for two or three minutes. (Judite)*

Judite describes the good doctor by opposition to the GPs with whom she contacted in Portugal and Cape Verde. According to her, a good doctor must be friendly, attentive, available, a good listener, thoughtful and familiarised with the patient. She also notes the need for certain medical routines of physical evaluation to be employed. By doing so the doctor proves his consideration and active interest on her condition. Recent experiences with GPs in Portugal who neglected to perform those medical routines re-shaped Judite's perceptions of their performance towards some negativity and dissatisfaction.

Participants often noted the importance of being able to rely on their GPs. Manuel explained the doctor-patient relationship should be based on mutuality and reciprocity, stressing the relevance of trust:

> *When we go to the doctor we must do things with respect... You can't go to the doctor and think he is obliged to do things. You must go there, explain what you feel and after that he must do his job. So the doctor must pay attention, must take the patient in consideration. He must be trustworthy.*

A necessary condition for reliance to emerge is the doctors' ability to 'do the job'. According to participants' expectations 'doing the job' entails the following set of

actions: taking the time to make the patient comfortable, questioning about the symptoms, performing physical examinations, making an adequate diagnosis and proposing an effective treatment, including referrals to specialists.

> *A good family doctor has to listen well. He must have time and not rush the consultation. He must also examine the body, ask questions, and do tests. If necessary the doctor must also send the person to the specialist. When the doctor doesn't know he must consult with another doctor to be sure about what the patient has. (Joana)*

These expectations indicate participants' preference for a more paternalistic approach to doctor-patient relationships. As stated above, participants experienced difficulties in obtaining referrals for specialised health professionals. While they expected to receive prompt and unconditional health care they were confronted with a situation in which they had to negotiate that care. Active involvement on treatment decision-making appears to collide strongly against participants' expectations of doctors' performance.

> *They [GPs] should be more interested on their work. They are the ones who studied and they should know better how to treat the patient. It's not the patient who must know how to treat herself. It is not our job to give the doctor ideas of what he must do to take care of us. After all who is the doctor he or we? It's not right. It's like we have to be our own doctors. (Dulce)*

The characteristics appointed as necessary to define a good mental health care provider resemble those of good GPs. However, in the case of the former emphasis is put to qualities such as the ability to be a good listener, to show interest and consideration, to prove availability and to bring rest to the patient. The most important feature of a good mental health professional was nevertheless the ability to provide a rapid solution for problems.

> *The psychologist must also listen very well. He or she must know how to calm down the person and help the person see reality. When one is like that it's not possible to see things as they are. He or she must know how to motivate the person that life is beautiful. Psychologists must be positive. They must show people solutions and the paths to take in order to get better as soon as possible. (Joana)*

> *I think a good psychologist must be thoughtful, must have time and patience, must be available for the patient and must do his best to help. The psychologist must be interested in hearing the person's problem and help her/him. (Judite)*

5

WHEN "HEALTH KNOWS NO BORDERS"

5.1 Discussion

This study was set out to identify what Cape Verdean immigrants in the Netherlands consider to be a good health professional. The results of this research point to a connection between Cape Verdeans' expectations regarding the performance of health care providers and the way by which their perceptions of what constitutes a good doctor are shaped. Previous experiences with health care systems in Cape Verde and third countries appear to influence Cape Verdeans' expectations of both health care providers' performance and their own roles as health care users. A conflict between participants' expectations of health professionals in the Netherlands and the sort of care they were provided with has been identified. It was also noted that participants experience, or experienced at some point in time, limited access to health care. All participants have however attempted to enhance their access to formal health care services either by adapting to the Dutch health care system and/or by resorting to transnational health care provisions. These findings might bring some insight on the question regarding Cape Verdeans' under-use of health care in the Netherlands.

All participants in this study are first generation immigrants who had experiences with health care professionals before they migrated to the Netherlands. These previous experiences contributed for the creation of a set of expectations regarding health care provision both in terms of the roles awarded to care providers and users. This was particularly evident through the comparisons made between health professionals in the Netherlands and in other countries as a way to define what characterizes a 'good doctor'. Most participants were confronted with an unfamiliar approach to health care provision when seeking for care in the Netherlands. In general, expectations of a paternalist approach to the doctor-patient relationship and decision-making concerning treatment contrasted with the perceived business-like relationship established. Expectations of unconditional and reliable health care collided with the perceived need to negotiate help and to adopt an active role when requesting care. These uncorroborated expectations had a negative impact on the perceptions of some participants regarding caregivers in the Netherlands leading some of them to define the 'good doctor' in opposition to what they encountered.

Some participants were able to find 'good doctors'. The encounter with a good health professional was nevertheless subjected to the participants' ability to adapt their help-seeking behaviour to the model prevalent in the Netherlands, i.e. to act as 'good patients'. According to the participants, health care providers act in a non-directive way, expecting the patient to provide a comprehensive account of the problems afflicting him or her and to be assertive when expressing health care needs. Those participants who were able to take on this role, acting as emancipated users and demanding information and participation on the decision-making concerning treatment, showed satisfaction with the care received and advanced few problems in consulting with specialists. They defined their relationship with professionals in the Netherlands as different from previous relationships with doctors elsewhere but these were nevertheless perceived as rewarding and adequate.

Yet, in other cases, participants experienced considerable difficulties in accepting a relationship with providers as the one described above. They seemed to be caught up on the riddle of converting treatments perceived as inadequate into appropriate care. Feelings of rejection, vulnerability and not being taken seriously as patients emerged and health care providers were perceived as untrustworthy, disinterested and negligent. These feelings and perceptions clearly undermined the establishment of good relationships with health professionals. In some situations, the inability to sort out these conflictive encounters was further enhanced by difficulties in speaking the Dutch language. However, the most critical element undermining successful communication appeared to be the short time awarded for consultation with GPs. The prescription of Paracetamol emerged as the exponent of inadequate care.

Both these groups of participants identified the existence of a conflict between the sort of care they expected to receive and the care they were provided with. They actively sought to access good quality health care services. However, they employed different strategies to reach this goal. As evidenced above, the first group engaged on a help-seeking behaviour more in consonance to the one expected from patients in the Netherlands. The second group, while attempting to sort out the riddle of accessing care in the host country, resorts to transnational health care use in countries such as Portugal and France and to transnational healing practices.

An analysis of the barriers hindering access to health care among the participants of this study might shed light on the factors leading some Cape Verdeans to engage on transnational health care seeking and on possible

strategies to improve their access to health care in the Netherlands. Three sorts of barriers have been identified: lack of information about the health care services available, problems with the relationships with health care providers and difficulties in dealing with the conditionality of help. These problems are deeply intertwined and relate to two sets of factors. At the macro-level, these include the organisational and structural characteristics of the Dutch health care system which has been increasingly subjected to the influence of principles of 'managed care' and consumerism and calls upon the proto-professionalization of health care users. At the micro-level, the problems concern the mismatch between users and providers' expectations regarding health care provision. The implications of the latter have been exposed above. The following attempts to bring insight on the impact of problems related to developments at a macro level.

Western health care systems have experienced in the last two decades an increased tendency for 'managed care', directed at the maximization of efficiency (Anthony, 2003). Managed care favours radical reorganisation of services towards the increase of the size of organisational units. It also strives to rationalise, standardise and monitor diagnosis and treatment (Ingleby, 2005). As observed in chapter 3, this process has transferred considerable power to health funders or insurers in the Netherlands. There has also been a shift from 'supply-oriented' to 'demand-oriented' procedures. This has meant a shift on users and physicians roles. Physicians experience stark pressure to act as entrepreneurs, being compelled by quasi-market forces to offer a good quality product at the minimum possible costs (Van der Oers, 2003). These directives are especially difficult for GPs to satisfy. The widespread shortage of these professionals forces them to undertake a considerable load of patients on their practices, limiting consultation time to as few as ten minutes per patient. Additionally, the variety of origins, ethnicities and cultures of the population in the Netherlands confront GPs with clients who display an increasing diversification of needs, explanatory models and expectations. Restrictions on consultations time and the implementation of standardized procedures might be hindering GPs availability to come closer to doctor-patient relationships and patterns of intervention which can take into account the diversity of the populations they serve. This study does not allow for a reflection on professionals' views on this matter. This constitutes a limitation of the study.

The implementation of principles of 'managed care' has also implied considerable shifts on the role attributed to users who are expected to act as consumers, creating the demand for different sorts of health care and se-

lecting the care provisions that best suits them. These developments call upon the 'proto-professionalization' of users, i.e. the adoption of fundamental stances and basic concepts used among professional circles in order to place articulate requests for care (De Swaan, 1990). Furthermore, it implies that doctor-patient relationships should be based on a symmetric instead of hierarchical form of interaction. Additionally, it brings about the need for organizations that can defend clients' interests by lobbying for 'tailor-made' care. Migrants in the Netherlands are both under-represented in users' organisations (De Graaf and Eitjes, 2004; Van Dijk, 2003) and insufficiently proto-professionalized, particularly where mental health care is concerned (Kortman, 2003). This also applies to Cape Verdeans and it seems to be particularly dramatic at the level of mental health care. Mental illness is considerably stigmatised among the Cape Verdean community and people often become isolated when such sort of complaints arise, out of fearing gossip and victimisation. This clearly undermines the proto-professionalization of the lay circles which Cape Verdeans belong to. Subsequently, the skills and knowledge necessary for negotiating the provision of effective care are hindered, creating asymmetries between users and providers and limiting the access to specialised care.

The developments described above might bring some insight on how some features of the Dutch health care system might exert a 'pushing' effect compelling Cape Verdeans into the perceived need for transnational health care use. It is relevant however to reflect on how characteristics inherent to health care systems abroad might work as incentives, 'pulling' the Cape Verdean community into making use of them or believing they can be provided with better care overseas.

Given the scarcity of comparative studies on health care systems, it is difficult to pin-point which characteristics of other European health care systems might enhance Cape Verdeans' access to appropriate care. It is known however that care provision differs considerably among developed countries. Payer (1989) has shown how national culture and philosophies of care underlie divergent medical practices in France, England, Germany and the United States, emphasising that the choice for and acceptance of diagnoses and treatments is culturally determined rather than scientifically based.

As evidenced in chapter 3, medical practice in the Netherlands follows predominantly a philosophy of prevention. Recent directives instruct practitioners to adopt an attitude of "watchful waiting" (NGH and LHV, 2002) before giving place to full-blown interventions. This often translates into what has

been described in the previous chapter as the 'paracetamol treatment' and gives rise to frustrations not only among migrants, but also among native Dutch patients.

The participants in this study also viewed this kind of treatment as inadequate. Furthermore, it appeared to call into question the authenticity of their complaints and their own integrity as people in need for care. Physical examinations, prescriptions of medications perceived as specific to particular ailments and ultimately, referrals to other health providers were seen as the required confirmation of their ill-health and the accepted procedures for arriving at suitable treatments. Such procedures are assumed to be more characteristic of health care in Portugal and in France. However, it seems that medical practices in those countries are changing. As stated by one of the participants medical examinations are not as customary in Portugal as they use to be. This situation has influenced participants' perceptions of doctors towards some dissatisfaction.

Perhaps one of the major differences between Portuguese and French health care and the Dutch system is the degree to which the GP can be bypassed when attempting to access specialised care. In Portugal referrals for specialised care are also determined by GPs and increasing efforts to promote their function as gatekeepers have been made in the last years. Yet, in practice, many people seek for care directly at the emergency department of hospitals and are referred immediately to specialists where necessary (Bentes et al., 2004). In France patients do not need a referral from GPs and can freely choose for a specialist (Sandier *et al.*, 2004). Thus the impact of problems arising at the primary care level is considerably different between these countries. While in the Netherlands a good relationship with GPs is crucial for the access to any other form of care in France and Portugal it might contribute for enhancing that access but it is not a necessary condition for it to occur.

The Netherlands has adopted a radically different attitude to that of Portugal and France in respect to health policies for migrant populations. Several reforms have been implemented as a means of promoting culturally competent and demand-oriented care for its diverse migrant population, including the creation of specific services for migrants, the set up of a national knowledge centre and the incorporation of 'cultural mediators'. This process is termed 'interculturalisation'. France, on the other hand, has adopted a passive attitude, reflecting a more 'assimilationist' ideology and emphasising migrants' adaptation to the existing services (Bollini, 1992). In Portugal,

awareness of migrants' health care needs appears to be increasing, but no specific multicultural care policies or programmes have been implemented at a national level[19] (De Freitas, 2003). These differences could lead us to think that the participants in this study would be more likely to benefit from appropriate care in the Netherlands than in the other two countries. This, however, conflicts with the reported experiences of the Cape Verdeans themselves. Cape Verdeans appear to have a clear idea of what sort of professionals suit their needs the best. In fact, the range of key-charecteristics reported as necessary to a 'good doctor' does not differ too much from that appointed by health professionals in Britain (see chapter three). Yet, despite these important competences, it is not always possible to find the 'good doctor' or create the conditions necessary to the establishment of a good doctor-patient relationship in the Netherlands. While trying to gain access to the Dutch health care system by adapting to its intricacies, the participants in this study explore the possibilities of other health care systems as a complementary strategy to find adequate care. The reliability of strong transnational ties, the maximization of resources made available through previous migration experiences, and a certain idealisation of the quality of health professionals outside the Dutch borders, all work to encourage the transnational use of health services.

Although health care provision in the Netherlands might be increasingly more responsive to the needs of the autochthonous population, it appears to lag behind regarding the satisfaction of migrants' needs. This seems to apply to the Cape Verdean community who does not make use of the services available as much as they would appear to need to. The problems faced by the Cape Verdeans concerning health service delivery exposed in this piece as well as the alternatives used to achieve good quality care contribute for the identified under-use of health care provisions. There is a generalised idea that migrants are not inclined to put much effort into seeking formal health care. The results of this study contradict this idea. Good health is highly valued among Cape Verdeans and no efforts seem to be spared to pursue it. As stated by one of the participants: "health has no borders".

5.2 Implications for research and practice recommendations

Even if occurring at different paces the growth and diversification of migrant populations has become a common trait of most European countries. In the last decades, migrants' health and health care needs have been the focus

19. A transcultural mental health care service is since recently available in the region of Lisbon, at Miguel Bombarda Hospital.

of increasing interest within policy-making, health care provision and academic research in Europe and elsewhere. This study has attempted to bring some insight on the health care needs of Cape Verdeans in the Netherlands by unveiling what they perceive as good professionals and, ultimately, good quality care. There is a need however to include health providers' views in the process of unravelling the way by which health care is delivered to and used by migrants. Furthermore, it is essential to understand the impact of the application of principles of 'managed care' on health care provision, both from a users and a providers' perspective. The directives applied to medical practice in the Netherlands appear somewhat paradoxical. Although it is expected from professionals to provide demand-oriented care they must nevertheless respect a series of standardised procedures and protocols which limit the scope of their interventions. The effects of these opposed practice referents on doctor-patient relationships are in need for further research.

The results of this study indicate the need for public authorities at large and health providers in particular to acknowledge and accept users' transnational health care resources and expertise in moving across borders and across health care systems. This is not only applicable to migrant clients but also to natives who increasingly choose for cheaper treatment options abroad. Yet, to envision the transnational use of health services as the only viable solution for good quality care might have dramatic effects. One of the risks inherent to using transnational health care in these terms is the delay often imposed to the initiation of the treatment process. A visit to the local health centre might take a couple of hours. Seeking care abroad demands for careful planning and availability of resources. Holding treatments in standby until all the necessary conditions are gathered might have severe consequences, exposing patients to greater risk of health deterioration and to the need for more radical interventions and longer recovery periods. This also brings extra pressure for welfare states creating an unnecessary overload on resources. There seems to be a need to revise and adjust the mechanisms and processes used on the implementation of cultural competent health care. This process calls upon the engagement of both institutions, health professionals, researchers and users and for multi-level intervention. The following attempts to provide some suggestions in that direction.

As noted, comparative studies on health care systems and health care use remain scarce. At the same time, there are marked differences between European countries in regard to the bulk of available data on the field of health, and in particular migrant health. Joint research projects between EU partners and comparative research might enable not only the creation

of networks of professionals who work towards a common goal but also the formation of a platform for exchanging ideas and 'good practices'. These platforms might be extended to institutions. Practices may not always be transferable but countries giving the first steps into the creation of culturally-competent health care might benefit from the experiences of others. Researchers and professionals can also profit from the creation of partnerships for action-research which envision the implementation of new services or shifts in care provision. The results of this study suggest that certain characteristics of Portuguese and French health care provision are more at consonance with the expectations of Cape Verdeans. The promotion of visits by health care professionals in the Netherlands to these countries could prove a beneficial exercise in raising awareness for alternative ways to improve the access of Cape Verdeans to health care. The 'reverse' strategy seems to be also of value. Two Cape Verdean psychiatrists were invited by Apoio-project for a visit to the Netherlands in 2004. They participated of a number of events in which they shared experiences with professionals, researchers and users in the Netherlands concerning Cape Verdeans' needs and use of mental health services, both at the home and host countries. This initiative was positively evaluated and alerted for the benefits of counting with critical and expert interventions from abroad.

Strong emphasis has been put into the involvement of users in health care by several Western countries. This practice has gained increasing attention and support since the 1980s. The reasoning behind the emergence of user involvement rests on the recognition that if the quality and access to mental health care are to be improved it is no longer enough to have change operating from within health systems alone. Few is known about the effects of the change imprinted on health services as a result of users' participation on the planning, delivery or evaluation of those services. The same holds true for the impact of user involvement on the way users perceive and make use of services. In the Netherlands, users are expected to have an active role on demanding for care tailored to their needs. However, as observed in the previous chapter Caper Verdeans appear to lack the most fundamental skill to participate – information about health services. The creation of a 'service guide' could enhance understanding of the ins and outs of the Dutch health system. It is important to keep in mind that such a 'guide' should be accessible in itself. This means not only the avoidance of professional jargon when presenting information and its availability in both Dutch and Portuguese but also a distribution of the 'guide' itself that takes in consideration meaningful points of passage and encounter for the Cape Verdean community. Information regarding patients' rights, insurance coverage, services available could

all prove of extreme use. A critical example seems to be the lack of knowledge on the right to book a 'double appointment' with GPs. This means that instead of the usual ten minutes awarded per visit the patient can have twice as much time when he or she perceives the need to have more attention from the GP. Once awareness and understanding of the available services is raised a step forward into promoting higher participation can be given.

APPENDICES

APPENDIX A

Topic list for interviews with informants:

1. Have you been to the doctor in the Netherlands? How was it like? Do you remember the reason of the first visit?
2. When you first visited the doctor how did you think it was going to be like? Was the consultation how you expected it to be? How different was it?
3. In what circumstances is one entitled to medical care in the Netherlands? Is it easy to find a family doctor?
4. With what sort of health care professionals did you contact so far?
5. Are there differences between the doctors in the Netherlands and doctors in Cape Verde?
6. Do you have any friends, family members or acquaintances that have been to the doctor? What did they think about it? Do you know if they were satisfied with their consultation? If not, what do you think it went wrong?
7. Are there other ways of getting help when you need it? What sort of help can you get?
8. How is your relationship with your doctor like? Are you satisfied with the way he/she treats you?
9. In your opinion, what characteristics do you think are necessary to a good doctor? Have you had contact with a health professional who you consider to be a good doctor?

APPENDIX B

List of key-informants who work with Cape Verdean immigrants:

1. Sofia Rocha – social worker of Apoio-project, Basisberaad GGZ, Rotterdam.
2. Madalena Lopes – social worker of Humanitas, Rotterdam.
3. Anabela Soares – social worker of Humanitas, Rotterdam.
4. Faquir Gulamo (Mito) – social worker of Avanço, Rotterdam.
5. Eunice de Carvalho – diaconal social worker of Nossa Senhora da Paz Church, Rotterdam.

Key-informant on issues concerning the philosophies within health care in the Netherlands:

1. Martijn Kole – staffmember of Cliëntenraad, Utrecht.

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