'BOOKING A DOCTOR'
COPING WITH HEALTH PROBLEMS IN THE NETHERLANDS:
A CASE STUDY OF FOREIGN STUDENTS AT ISS AND UVA

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Preface

This ethnographic research is based on a six weeks fieldwork period carried out in two educational institutions in The Netherlands, University of Amsterdam (UvA), Amsterdam and Institute of Social Studies (ISS), The Hague. The study limited itself to only a small sample of foreign students staying in the Netherlands from six to forty-eight months.

The need to understand and improve the health situation of foreigners in the Netherlands has been of concern. However, foreign students as a category of foreigners has so far been neglected by researchers, especially their health and health care.

The study explores and describes the ways in which foreign students are dealing with health problems during the study period in relation to the Dutch health care system. Students having home-influenced expectations that are not congruent to the Dutch system find difficulties in coping with their health problems.

The findings reveal that although students have health services in place, information provision and dissemination is inadequate. There are other intervening factors like making appointments, selection of GP, doctor-patient interaction, expected diagnosis and treatment. All these factors have an influence in the quest for therapy from the different therapeutical alternatives, ranging from formal to informal sources, in most cases a combination of both. This also has an impact on patient's satisfaction.

To have further in-sight of how foreign students deal with health problems, it is important to recognise the role of the therapy management group which is composed of friends and colleagues. It is famous among others for provision of information, medical, and psycho-social support to these students.

In many ways, it is through the findings of this study that policy makers in the field of health, health providers and educational institutions could understand the health problems of foreign
students and how the students deal with them. This will help to formulate more realistic service delivery policies to cater for the students.

I would recommend health professionals as well as educational institution service providers, psychiatrists, social workers and researchers at all levels to get acquainted with the findings reported. I would also advise the foreign students to read this report to have in-sight in their health care situation in the Netherlands.
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Chapter One

Introduction

The Netherlands has a long and outstanding tradition of accepting foreigners. This tradition dates back in the 18th and 19th centuries when the country was known as a port of refuge especially for those persecuted in their countries for political, religious reasons or unaccented theories (Spruit 1987: 203).

In recent times, there has been an increase in the number of migrant groups from all over the world. Demographic data for the Netherlands for the year 1991 showed that over 6% (over 900,000) of the Dutch population were of foreign nationality or from one of the former Dutch colonies (Venema et al. 1995: 809). Of the population of approximately 15,000,000 in the Netherlands (in descending numerical order), there were 219,000 Surinamese; 198,000 Turks; 157,000 Moroccans; and 71,000 Antilleans.

Several studies have shown that these migrants came to the Netherlands in search for better political and socio-economic environment, but with a hope of returning to their native countries (Bollini et al. 1995: 821; Spruit 1986: 203-207; Venema et al. 1995: 809). Thus, they were officially considered to be migrants and they constituted temporary labour. To some however, the notion of returning home seized.

During the last three decades, the Dutch government has put a halt to the recruitment of foreigner labour (Spruit 1987: 201). However, one notable group of foreigners that is still admitted into the country are students from all parts of the world. International exchange between universities is increasingly encouraged to extent that an increase in the number of foreign students is to be expected. The UNESCO Statistical Yearbook (1997) indicates that in 1990 alone, the number of foreign students in the Netherlands was 8,876. In 1992/93, the number had increased to 11,389. An estimated 5,317 of them were from other parts of Europe; 2,913 from Asia; 1,488 from South America; 1,144 from Africa; 423 from North America; 54 from Australia; and 59 students from former USSR (UNESCO 1997: 379-411).
The figures above suggest that foreign students in the Netherlands constitute a minority community with diverse culture in relation to health care (De Jong 1986). Some studies have argued that foreigners originate from cultural backgrounds that are different from those of the host country (Colledge et al 1986), which sometimes are shaped by the changing circumstances (Helman 1994: 12; Venema et al 1995).

Both local and provincial authorities regulate the Dutch health care system (Bruins 1989: 3). It has been anticipated that for an outsider to get located into the Dutch health care system, a comprehension of the social health insurance system is necessary (Schrijvers 1997: 23). A fully developed social security system ensures that a wide range of professional health care is available and accessible to everyone in the country; through the ziekenfonds or private health insurance.

However, as pointed out by Spruit (1987: 207) the system is sometimes complicated, to the extent that patients as well as doctors get lost in it. Reflecting upon a personal experience:

In August 1997, I came to the Netherlands from Uganda to follow a one year master’s degree course in Medical Anthropology at the University of Amsterdam. Three weeks after, I fell sick and was advised by friends to consult a General Practitioner (huisarts). At first glance, the Dutch health care system seemed straightforward not until I was confronted with it. Before consultation, I was asked if I was insured and whether I had made an appointment prior the visit. In addition, I did not know which language to use during consultation - the entire process was not only strange to me but also confusing. I wondered whether other foreign students shared similar experiences.

Literature on the relationship between migrants and the Dutch health care system has tended to overlook foreign students. There is the idea that foreign students are temporary residents; expected to return to their countries of origin after completion of their studies. Thus, pose no serious burden to the health system. Secondly, the oversight also stems from the fact that foreign students normally have a high level of education which enables them to adapt easily to the different cultural settings. Lastly, foreign students are expected to have had a medical examination in their countries of origin before going to study (Spruit 1987: 210; Nuffic 1997). I feel that these notions need to be re-examined.
Many medical anthropologists might argue that although ill health is a common phenomenon to all human beings, cultural and individual interpretations differ. Similarly, ways to seek health care or deal with ill health/health problems might differ. Therefore, the presentation is occasioned by two basic questions:

1. How do foreign students deal with illness? And
2. If culture is important in explaining health issues; is it the same for foreign students as a community, or do they create a new create of dealing with ill health?

The study examines the processes and mechanisms that are applied by foreign students in adapting to the Dutch health care system. The need to study the coping strategies for foreign students in relation to existing health care system stems from the following factors: global outreach for migrants' health; cultural influencing perceptions of illness/health and health care; communication problems and inter-linkages; diverging expectations from a particular health care system; perception of a ‘foreigner’; and understanding the various ways in which the health care system functions.

To explicitly understand, conceptualise the above intervening factors and fill up the gap at a micro-level, I carried out a short-term ethnographic study of a small sample of foreign students at two educational institutions in Amsterdam and The Hague. I hope to contribute not only to the knowledge of Dutch health care for foreign students, but also to the improvement of policy making and delivery of services.

**General objective**

To document the different ways and mechanisms through which foreign students at UvA and ISS deal with ill health while in the Netherlands.

**Specific research questions**

1. What are the different ways through which foreign students deal with illnesses during their study period;
2. Do foreign students understand how the health care system functions, including the health insurance system;

3. How do foreign students describe their experiences and/or interaction with the General Practitioners;

4. What kind of communication problems exist between foreign students and the General Practitioners;

5. Does the Dutch health care system meet the needs and expectations of foreign students;

6. From the results obtained in questions one to five, is it possible to improve the interaction between foreign students and health providers, thus improving the quality of care?

Organisation of the thesis
This study consists of five chapters. In Chapter one I introduce the background of the problem and state the study's general objective and specific research questions.

Chapter two contains a detailed description of the entire research approach. It deals not only with data gathering and processing techniques, but also with fieldwork procedure and ethical aspects.

In chapter three I give an overview of health care services in place in relation to Dutch society in general and the Dutch health care system in particular. For comparison reasons, I also discuss students’ health care back home, using the case of Uganda as an example.

The expectations and experiences of both foreign students and health care providers are analysed in chapter four. The main topics are: selection and ‘booking a doctor’; health problems; consultation; diagnosis and treatment; and patients’ satisfaction.

Chapter five entails the conclusion and recommendations.
Map 1. The Netherlands

Map 2. Location of study area - Amsterdam (UvA)
Map 3. Location of study area - The Hague (ISS)
Chapter Two

Research approach

In this chapter, I describe the entire methodological approach, the study area and population, choices of data collection and sampling techniques. I also discuss the plan/procedure of data collection, ethical aspects, data processing and analysis issues, and problems that I was confronted with during the field study.

Study area

The study was carried out in Amsterdam, the Capital City, and The Hague, the political and administrative centre of The Netherlands. Within these cities, I focused on the Institute of Social Studies (ISS) and the University of Amsterdam (UvA) respectively. The choice of these cities and institutions was purposive. First, Amsterdam and The Hague are among the biggest cities in the Netherlands with a residential population of approximately 750,000 and 450,000. Secondly, these cities have a long history of welcoming foreigners. They are known to have the highest population of foreigners in the Netherlands, among which are the foreign students.

The ISS is located in the centre of The Hague within walking distance of key institutions such as ministries, embassies, the International Court of Justice and the Royal Library (see map of The Hague on page 6). It is a graduate school founded in 1952 specialising in international policy-oriented social sciences teaching, inter-disciplinary research and advisory work to the field of development studies. The institute runs a wide variety of teaching programmes in English from short courses of one month to long courses of four years. Since it was founded 8,000 students from more than 160 countries have participated in the institute's programmes with an in-take of over two hundred students every academic year. The highest number of participants are from Africa and Asia. For example, from September 1997 to December 1998, 223 students were registered. Ninety-six participants were from Africa; ninety-four from Asia; twenty-five from South America; twelve from Europe; five from North America and only one participant from Australia. Most students lived close to the institute.
Amsterdam possesses the largest centre of study in the country, the UvA, with most departments located throughout the city centre (see map of Amsterdam on page 5). The basis of the university was formed in 1632, when the Athenaeum Illustre was founded to train students in trade and philosophy. In 1877 it became the University of the city of Amsterdam and granted permission to confer the highest degree. The university offers courses mainly in Dutch but a variety of international programmes are taught in English. Today, over twenty thousand students are enrolled annually. Majority of the students are Dutch, with a few foreign students. According to the Facts and Figure leaflet of UvA, at the beginning of 1998 a total of 22,000 students were registered with only 1,065 foreign students. There are no clear figures of the latter's countries of origin, however. The students' residents are not concentrated near the faculties, but all over Amsterdam.

I selected these two institutions also for comparison purposes. While ISS has a long known history of training foreign students, especially from 'the South' (Africa and Asia), Amsterdam has only a recent intake. This aspect underpins that there might be differences in the provision of health care services to foreign students as discussed later in Chapter Three and Four. Besides, I was student at the UvA studying, living and interacting with fellow students from abroad and acquainted with some ISS students from the above mentioned continents.

Study population

Foreign students
The main informants were foreign students from different countries in Africa and Asia at the UvA and ISS following courses for six months to forty-eight months. Thirty informants were selected, fifteen from each institute. I was dealing with a relatively small population whose members were in close contact with each other. They were studying together and/or staying in the same hostel or apartment. This created a 'sense of community' among them. Considering these factors, snowball sampling was employed.
Prior to my fieldwork, I came to know fellow foreign students and discussed my research ideas with them. Among those I met for example, was a female student from Kenya at UvA who readily accepted to participate in the project. Through her I got to know more informants who in turn referred me to others. At ISS, for example, the Welfare Officer being 'the spin in the web' was a useful source of information concerning the general health problems of and services for the students. Also I asked fellow students, GPs, staff at the foreign students office and programme co-ordinators for places of residence. Using these techniques, I was able to explore not only the social network structure that existed among foreign students but also what they experienced and expected in relation to health problems and care.

To supplement snowball sampling, quota sampling was used. I tried to categorise the thirty informants into more or less equal proportions of gender distribution. This provided a desirable balance of gender distribution of the study population for purposes of description of health problem experiences. To avoid generalisations of continents, I interviewed respondents from different countries in Africa and Asia.

For information about the informants see table below. For more details see Appendix 1.

<table>
<thead>
<tr>
<th>Education institutions</th>
<th>Number of students selected</th>
<th>Distribution by sex</th>
<th>Distribution by continent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>UvA</td>
<td>15</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>ISS</td>
<td>15</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>13</td>
<td>17</td>
</tr>
</tbody>
</table>

*Table 1. Student respondents*

*General Practitioners*

My familiarity with the health care system as a patient, as mentioned earlier in the introduction, made the selection of GPs easier. At UvA, I was a patient of one of the student doctors (*studentenartsen*). With her, I discussed my interests. Later, she became one of the informants and introduced me to other GPs in the same clinic. Both in Amsterdam and The Hague, I also came to know other GPs through their patients (students interviewed). Furthermore, one of the members of the Dutch Association of Family Doctors (*Landelijke Huisartsen Vereniging-LHV*) was also helpful in this respect.
The selected GPs were requested to introduce me to at least one other GP who had had experience with foreign students. It was my intention to take into account the gender of GPs for purposes of creating a balanced sample. Due to the limited time schedule of the fieldwork and unavailability of some of the GPs (holidays, too occupied with work, etc.), I did not succeed to reach the desired gender division. The male GPs were over-represented. I interviewed four GPs, two male GPs in The Hague, and one female and male in Amsterdam.

Other key informants

Other key informants were deliberately selected. These included: one welfare officer (ISS), three public relations co-ordinators for foreign students (UvA), two programme co-ordinators, the Dean of students (UvA), two board members of the Dutch Association of Family Doctors (LHV) and the Dutch College of Family Doctors (Nederlands Huisartsen Genootschap-NHG).

During fieldwork I discovered and was advised that students' psychologists would also have been worth taking into account. Initially, I had ignored this category as I had no idea of their role in Dutch health care. Later, I corrected this omission and interviewed one in The Hague. In Amsterdam, however, due to difficulties making appointments and limited time of fieldwork, I did not interview any students' psychologists dealing with UvA students.

I tried to back up all the above mentioned sampling techniques with the ethnographic data below, thus making them valid and reliable.

Study type

The study was exploratory and descriptive trying to answer 'how', 'what' and 'why' questions that enhanced the understanding of foreign students and the Dutch health care system. Qualitative research was seen appropriate for the study when looking at the basic assumption.
The purpose of this qualitative research was to formulate a description which gives sense to and insight in the views of the informants (foreign students and health providers).

**Data gathering techniques**
The study relied upon primary and secondary sources of data collection.

**Primary data**
Primary data entailed qualitative methods of data collection. Among which I used: semi-structured interviews, case studies, in-depth interviews, clinical encounter observation, small group discussions and key informants.

*Semi-structured interviews*
A general semi-structured questionnaire (see Questionnaire A, Appendix 2) was designed and administered to foreign students selected for the study. The questionnaire had a combination of closed-ended and open-ended questions which permitted collection of in-depth information and exploration of spontaneous issues by the informants. This involved using themes and sub-themes as topics for discussion. To avoid writing which could lead to long breaks, loss of eye contact between interviewee/interviewer, low concentration and loss of valuable information during interview sessions, interviews were tape recorded. With recording the interviews I had ample time to make immediate clarification and call backs after transcription to particular respondents about some vague and unclear information given. The interviews lasted for about 30-60 minutes (see implementation of fieldwork schedule). The informants were requested to give views on the following question:

- What are the foreign students' experiences with the Dutch health care system?

Other sub-questions/topics for discussion that were formulated to give insight of the general situation of foreign students and the Dutch health care system are indicated below:
- Have you had any health problem while in the Netherlands;
- What kind of treatment;
- Other forms of treatment used;
- Person consulted for the health problem before going to the doctor;
- Procedure of consultation;
- Choice of therapy;
- Doctor-patient communication;
- Health insurance system;
- Patient's satisfaction
- Problems accounted during consultation.

Case studies of foreign students

In order to supplement the semi-structured interviews, case studies of foreign students were developed. I built my case studies on retrospective cases i.e. students who had ever experienced illness episodes during their study period in the Netherlands and particularly those who had ever consulted the GP. I asked them to explain and give a narrative (Questionnaire B, Appendix 3) of their experience about the following themes:
- The procedure of consultation;
- Choice of therapy;
- Doctor-patient interaction;
- Evaluation of interaction and expectations;
- Patient's satisfaction;
- Problems accounted during and after consultation.

To respond to the above themes, two students were selected. One female from UvA and a male from ISS. Criteria of selection were based on the frequency of consultation and some complicated/emergency cases. For purposes of appropriate selection of respondents, I also held informal discussions with friends and colleagues about ways of assisting each other during an illness episode. The case studies are presented in chapter four.

In-depth interviews

For one to understand how the foreign students were dealing with health problems while in the Netherlands, it was imperative to explore the health providers' experiences with foreign students as patients. GPs as gatekeepers in the Dutch health care system are an important category of health providers. I conducted in-depth interviews (see Interview Guide, Appendix 4) with selected GPs who were dealing with or had experience with foreign students. These
took mainly place in their offices. This information added a different perspective (triangulation) of information collected from foreign students and observation made during the study.

The topic of discussion entailed:
- Doctor-patient interaction;
- Doctor-patient communication (explanatory model, interpretation of illness);
- Health problems presented;
- Any special attention given to foreign students as patients;
- Expectations about treatment, satisfaction-use of other medications or specific treatment.

Clinical encounter observation
Another method that was used to collect data was clinical encounter observation. This gave a more detailed and context-related information of what really took place at the clinic when the foreign student as a patient went for treatment. Ample time was spent during consulting and non-consulting hours thereby bringing me closer to the reality. In The Hague, I carried out clinical encounter observation at a private clinic of one of the GPs; and at consultation room for students at the institute premises. In Amsterdam, during my clinical encounter observations at the university clinic no foreign student patient showed up.

In both Amsterdam and The Hague, I used a clinical encounter observation form (See Appendix 5) which enabled me to have insight into what went on at the clinic. At ISS however, I observed what went on from the time the patient entered the clinic to the time she/he left it. In Amsterdam, I could only observe the general setting of the clinic. The following were reference points:
- Communication at the reception table;
- Requirements before consultation;
- Doctor-patient interaction during consultation;
- Medical equipment available;
- Doctor-patient's expectations (satisfaction and treatment);
- Duration of consultation
- Any explanation from both the patient and doctor about the illness.
I had four sessions of clinical encounter observation in The Hague. In the consultation room, I took different views. In order not to lose track of what was happening I avoided jotting down issues at that moment. As the patient left the consultation room, I too left to make an appointment with her/him for later discussion. This was also an opportunity for me to jot down some of the observations I had made. To avoid inconsistency in observations, the above described procedure was used for all the patients.

**Small group discussions**

To supplement all the above data that was collected using interviews and clinical encounter observation, small group discussions were held. Eight group discussions were held with foreign students, those who had ever and those who had never consulted a GP. Of course there were some students who had experienced illness episodes during their stay in Amsterdam and The Hague but refined from visiting a GP. It was interesting and important to find out why? Just like in many countries where foreign students prefer to use self-medication or simply are not interested in using health care services. So with that assumption, I inquired from foreign students the reasons/motivations for or not consulting the GP.

Small group discussions were held in different contexts: over a cup of tea/coffee at the place of residence of the student; on occasional visits to the hospital (during the research period three students were hospitalised); in situations when a sick person needed medical assistance (therapy management group); and on the way to the city centre for shopping or sports. This could go as follows. I was seated in a coffee room waiting to go to the computer room and someone came up, asking: 'How are you today? What are you doing here? Are you a new participant? A cup of tea/coffee?' I would then introduce myself and what I was there for.
This could mark the beginning of a thirty to forty-five minutes discussion in where one or two other people would join us. Sometimes there were arguments about expected diagnosis/treatment (discussed in chapter 4), especially if the group was composed of a person who had never consulted a GP. These discussions had added advantage as informants were familiar with each other since they were in the same situation (all of them foreign students). They were free and open about their views compared to one-to-one interviews. This technique animated articulation of opinions of foreign students about themselves in the Dutch health care system. It also offered a chance for generalisations.

Discussions with key informants

Discussions were held with other key informants as well, as mentioned in the study population. These people play an important role in making and implementing health policies. The theme for discussion was: foreign students and the Dutch health care system. These discussions were aimed at exploring whether there is any health policies/services in place for foreign students. And how is the information about the Dutch health care system disseminated to the foreign students? These were interviewed at their places of work, or place of their own choice. For better discussions, I fixed appointments with them before.

Secondary data

Secondary data collection involved a review of existing documents about different aspects on foreigners and Dutch health care system. Historical reports about recruitment of foreigners and statistical year reports concerning population figures of foreigners-migrants/refugees/foreign students were reviewed. Other documentation resources included: clinical records, brochures, leaflets, health policy reports, journals and Medline with related information about foreigners and health care systems.
Schedule for data collection

Prior to the actual fieldwork which began in week 4 of May 1998 for a period of six weeks, I carried out three main pre-visits and occasional visits to the areas of study. All these visits were intentional, for identification and establishment of rapport with as many of my would-be informants as possible. As mentioned earlier, I already knew some of these personalities but others were suggested not only by foreign students but also Dutch people and other foreign residents. First pre-visit was made in week 1 of May 1998 in search of a suitable clinical setting. Locating the clinics was not difficult as anticipated earlier. My familiarity with the university clinic in Amsterdam had an added advantage. With the help of my GP, a staff at the same clinic and a letter of introduction about my project, my initial plans were approved.

In The Hague, the welfare officer and informal discussion with fellow students proved important and of great assistance. Through informal discussions of which GP most students consulted, one name was always mentioned. To me, this was a trigger towards the right person I had been looking for. I contacted him immediately, discussed the purpose/plans of my study which he agreed to.

In week 2-3 of May 1998, I had two pre-visits to make final arrangements and appointments with my informants suitable for interviews or discussion. Other methods used for making appointments with informants while in the field included: telephone calls, leaving verbal messages with colleagues or written messages at their residence, and e-mail.
Actual fieldwork schedule is summarised in Table 3 below:

<table>
<thead>
<tr>
<th>Tasks to be performed</th>
<th>Period to carry out task</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pre-visit search for suitable area of study and clinical setting</td>
<td>week 1 before actual field work May 1998</td>
</tr>
<tr>
<td>2. Clearance and orientation of GPs, policy makers and foreign students about the research</td>
<td>week 2-3 May 1998</td>
</tr>
<tr>
<td>3. Interviews with foreign students of the Institute of Social Studies (ISS), The Hague.</td>
<td>week 1 actual field work June 1998</td>
</tr>
<tr>
<td>4. Exist-patient interviews, interviews with GPs, participant observation at the clinical setting at ISS, The Hague.</td>
<td>week 2-3 June 1998</td>
</tr>
<tr>
<td>5. Discussions with key informants, policy makers and implementers, small group discussions with foreign students at ISS</td>
<td>week 3 June 1998</td>
</tr>
<tr>
<td>6. Interviews with foreign students of University of Amsterdam (UvA), Amsterdam</td>
<td>week 4 June 1998</td>
</tr>
<tr>
<td>7. Interviews with foreign students (case studies), interviews with GPs, participant observation at a clinical setting in Amsterdam</td>
<td>week 5-6 July 1998</td>
</tr>
<tr>
<td>8. Discussions with key informants, policy makers and implementers, small group discussions with foreign of UvA</td>
<td>week 6 July 1998</td>
</tr>
</tbody>
</table>

Table 3: Fieldwork schedule

Implementation of fieldwork schedule

Setting up a fieldwork schedule is a tool used at least by most anthropologists at one time in life. To many of them, the time frame is always observed in order to achieve the specific goal set. However, in practice things go in most cases differently than in theory. From the above table, I intended to spend three weeks in each of study areas but I found it impossible. I spent more than one week extra in Amsterdam as a result of various problems mentioned below. Because of this I was able to conduct most of the interviews I had planned.
On average, interviews lasted for at least thirty minutes to one hour. These were held in a place and time selected by the informants but also conducive for tape recording the interview i.e. in a quiet place. Common places for interviews included: student’s rooms (giving opportunity for observation), mensa academica (Atrium) and coffee room.

In some cases, however, interviews took about two hours because often respondents gave winding answers in a narrative form which was anthropologically interesting and valuable for my findings. This is an example of how it happened:

**Interviewer:** Have you had any health problem while in The Netherlands?

**Student:** (silence)...aaah, yes. But generally my health has been good. Only that initially you know I had stress, missing my family...er... Constant headaches so I had to consult a doctor. Actually before I saw the doctor I went to the social worker who called the doctor. But I ...also inquired from friends whether I should see the doctor. You can not imagine what happened, I was so scared. Any way, then,... I went to see the doctor who asked me how I was feeling [...]. I also had high blood pressure (HBP) before I came here, so I had to consult a doctor, etc.

I observed that questions concerning history of health problems created opportunities for getting back and forth the point of discussion. Such situations however, created a time-lag especially as I had to operate within a certain time frame.

**Data processing and analysis**

Due to the fact that the information collected was qualitative, it was processed and analysed during fieldwork. This entailed: transcribing of data from the tape, categorising responses according to the themes or sub-themes, making matrices, flow charts and case studies.

Research questions were analysed by noting the inter-relationships among the given responses, presentation of selected anecdotes and comments from informants. This involved the sub-themes and sub-problems in the questionnaires and interview guide, for instance: doctor-
patient relationship, choice of therapy, expected medical services-foreign students and GPs' perspective.

To underpin and offer visual display of the data collected, I used matrices and tables. This involved laying out the information collected in a table about factors influencing the way foreign students deal with health problems. With the aid of visual representations of ideas that emerged from the informants about themes like: access to health care services, communication between health providers and foreign students, I was able to see how much a particular pattern of ideas is shared among informants.

In addition, to give an overview of steps involved in health seeking behaviour, a flow chart was employed (chapter 3 and 4). These charts facilitated me to come up with practical conclusions about what causes what in terms of service delivery, how different categories of informants (students, GPs and policy makers) thought and viewed about the Dutch health care system. For each pattern of ideas, I went through my notes, tried to extract relevant responses and make observations of the informants behaviour during the interview or discussion.

Editing

Responses were checked after interviewing each respondent in the field. The distribution of each of the variables was examined and cross-checked for possible errors or omitted topics during the interview discussion. This was done with a colleague at night after transcription of the interviews. Comparing transcriptions in this manner proved to be effective for conducting consistency checks. I made call-backs to ensure quality and validity of data gathering, sent e-mails on which I attached a copy of the interview requesting for clarification in cases of vague/or unclear statements.

Ethical considerations

In every study or research project in relation to human beings ethical considerations are at the fore-front. Before any interview or discussion held (with students, GPs and other key informants), I gave a brief introduction to explain the purpose and scope of the study.
Informants were encouraged to give their own views and suggestions openly. Also they were given chance and time to ask for clarification about unclear points or to add omissions later on.

I assured my respondents that all information given would be treated confidential and anonymous. Many anthropologists have given special explanation to the technique of tape recording. These points were stressed to the foreign students since I was a participant in their community on the one hand, and on the other 'studying' them.

**Problems encountered**

During the preparation and actual fieldwork I encountered some problems, which included:

1. Language problems during literature review, i.e. some literature relevant to the study was in Dutch and had to be translated in English.
2. Unexpected payment for consultation with GPs about the study and asking them to participate in the study. This caused more mental destruction when I received another bill during my report writing period.
3. Dispersion of students' residences in Amsterdam required a lot of searching and travelling.
4. The Dutch culture of making appointments. Without an appointment, it is hardly possible to meet someone. This involved high telephone costs and took a lot of time.
5. From time to time, it proved very difficult to make appointments with some GPs. It could take some days or even a week.
6. Delay in funding of the research.
7. Computer breakdown in the initial stage of the fieldwork.
Chapter Three

Foreign students and the Dutch health care system

In general terms, the choices people make and the considerations behind these decisions are in one way or the other circumscribed by the macro-level, social-economic and political order in which their lives are embedded. In spite of my study being at the micro- (community-) level, the health and health related problems which confront the community members, the decisions and sacrifices made especially in their quest for 'good health' cannot be grasped without considering the political economy of the country in question. This perspective is put forward by critical medical anthropologists (Singer et al 1995; Sachs et al 1991). Therefore, in the discussion below I will try to bring out a clear view of health services which are in place for foreign students (at ISS and UvA) in relation to Dutch society in general and the Dutch health care system in particular. But important too is to understand how the Dutch health care system functions in relation to the health care system back home. A case study of Uganda's health care system (which could be considered exemplary for other countries in 'the South') will be brought foreword. I will begin by providing an overview of the Netherlands looking at a few factors that could have an influence on the health of its inhabitants.

The Netherlands: An overview

The Netherlands is a small country situated in the north-western part of Europe. It borders with Belgium to the south, to the east is Germany. In the north and west, it is surrounded by the North Sea. The country covers an area of about 41,865 square kilometres, including the large water-bodies of Waddenzee and Ijsselmeer. The land covers about 33,800 square kilometres (see map of the Netherlands on page 5).

With about fifteen million inhabitants including foreigners, the Netherlands is the fourth densely populated country in the world (after Bangladesh, Taiwan and South Korea). The population density is estimated at approximately 377 people per square kilometre. This is an average if one considers that 60 percent of the population lives in West Holland conurbation,
an area covering one sixth of the country. This is in the so-called \textit{Randstad} which is the triangular-shaped area bounded by Amsterdam, Rotterdam and The Hague. The commonly spoken language throughout the country is Dutch, with various regional dialects, mainly the northern and southern. Although most Dutch people speak English, it is not always fluent thus creating some communication problem to foreigners including the students.

The country is very flat, with a few hills ranging from about 100 to 341 metres in the south-east part. Significant and easily visible also, are the water stretches; lakes, rivers, estuaries, canals and omnipresent ditches lying below sea level (polders draining the low grasslands). Due to being partly under sea level, having limited land and a lot of water stretches, the Dutch are for a long time famous for their struggle against the water and for reclamation projects to cater for the population. This explains why hardly any patch of land is wasted in the Netherlands.

The climate of the country is temperate (maritime climate) having winters with day temperatures around or below freezing point, often with strong winds. Severe frost and snow are rare in winter seasons. If you spent a winter in the Netherlands, by March you would understand why the Dutch people glorify sunshine in the South. Summers which are hot and sunny (with an average about 30° C day time and 20° C at night) are an anticipation for most people. However, more often than not Dutch summers may turn out to be a disappointment, just cool and cloudy. In addition, rain and high humidity can occur in all seasons, making winters chilly and summers sticky. As the weather is generally changeable and very unpredictable, it is a common topic of discussion in casual conversations. Moreover, it could directly/indirectly affect the health of many Dutch and foreign people.

The main assets of the Netherlands have always been the fertile land and its favourable location; the rivers and the sea stimulating trade. No doubt related to its fertile soils, Holland has a strong agricultural image abroad (Vossenstein 1997: 104). However, the abundant output of agricultural products: milk, cheese and flower bulbs represent an unrealistic picture. It accounts for only 3.8 percent of the Gross Domestic Product (GDP) and employs less than five percent of the working population. The Dutch economy is mainly industrialised and service oriented, accounting for 28.1 percent and 72.2 percent of the GDP, respectively. Her
major exports include: natural gas, oil, machinery, electronics and agro-industry products (mentioned above). In addition, there are transportation and other service-oriented facilities offered like banking and insurance.

Due to a tradition of coalition government, the Netherlands belongs to the politically most stable countries in Europe. It also ranks amongst the richest and economically stable European countries, with a GDP of US $ 21,700 per head of population in 1994 (Boonstra et al 1996: 107). In the nineties, her unemployment levels are known to be one of the lowest in Europe. A strict taxation policy prevents the gap between high-and low-income groups from widening (total taxation accounting to 48 percent of the GDP). An elaborate system of social security furthermore, guarantees social benefits for the old aged, the mentally and physically handicapped, the unemployed and employees who are missing their salaries/wages due to sickness.

Approximately, the total health care expenditure as a percentage of the GDP is 8.7 %. Ranking in the fifth position, the Netherlands' health care costs tend to be slightly higher than in other European countries with tax-based health care systems. Reason being that the Dutch system is generous in reimbursing providers and insurers. And as a matter of fact, the share of health care costs financed by insurance should really be considered public, since citizens do not have a choice as to whether or not to pay premiums (Schrijvers 1997: 24-26).

The Dutch health care system

*The health care system in the Netherlands - High standards, yet...*  
(Vienonen 1997: 23).

To any outsider or observer, the range and diversity of health care service delivery in the Netherlands seem overwhelming. At present most of the intra-and extra mural health organisations are under private ownership, non-profit institutions of general practitioners, pharmacists and many of the specialists, including dentists. These provide primary, emergency and secondary health care. In addition, a remarkable range of services exists owned and
managed by independent voluntary organisations (from which the health care system originated), non-profit religious and other groups, offering health and welfare services (Borst-Eilers 1997: 17).

Accessibility to medical care services is ensured through a fully developed social health insurance system. Here, I will have a glimpse at it in order to show how complex the system is and how it operates. Approximately 70% of the population (those with an income under a specific 'wage limit' fixed by the government) is covered by the national social health insurance, ziekenfonds (Spruit 1987: 208; Vienonen 1997: 24). It directly insures one against medical expenses like treatment by a GP, certain types of services offered by specialists, medicines and nursing in hospital. In some cases an individual contribution is to be paid. Both employee and employer contribute to the Fund in the form of premiums, the employee's share is automatically deducted from his/her wage. Social benefits also fall under this regulation so that the unemployed, the elderly, mentally and physically handicapped etc. are members. Selection of GP by the insurer is not entirely free. The choice depends on location of residence and has to be approved by the ziekenfonds. Reason being that the number of ziekenfonds - patients per GP is limited.

The remaining 30% (those not compulsory insured in the ziekenfonds) is privately insured. The premiums which are paid in the form of fixed, nominal accounts, vary according to the package of services offered by the private insurance companies. The costs of medicines and treatment by a GP, if covered, have to be paid by the insurer for every consultation. These expenses are reimbursed after sending a requisition to the insurance company (exceptions are possible dependent on the agreement made between health providers and companies). Selection of GP is entirely free, only dependent on insurer's preferences and GP's approval.

The ratio of medical personnel to inhabitants has been controlled to a level of 2.5 physicians per 1000 inhabitants (Vienonen 1997: 27-28). The professional density per 10,000 patients/clients is 5.7 specialists in the 27 officially recognised specialities, 3.7 GPs, 3.5 dentists, 0.4 mid-wives and 0.8 pharmacists. In principle the patient can only initiate primary care provided by the GPs (family doctors-huisartsen), district nurses, home help, midwives, physiotherapists, social workers, dentists and pharmacists.
Most of the medical problems are treated by the GP/family doctor. (S)he is 'specialised' to deal with common and minor diseases, and care for patients with chronic illnesses, including psycho-social problems related to these complaints. Most GPs practice independently, own their own offices, and are assisted by a practice/doctor's assistant. (S)he serves as a receptionist and can also help with minor surgery, laboratory work and blood pressure reading. By policy, GPs are required to be available 24 hours daily, seven days a week. Evening, weekend, and holiday coverage of patients is by a group of family doctors (Centrale dokters dienst).

On average, each GP has about 2300 patients, and has a role of gate keeping (Schrijvers 1997: 63). This role denotes that patients do not have access to specialists or hospital care. The GP channels patients with complicated and non-comprehensive health problem, and/or need of expensive specialist care to specific expertise and highly medical technology skills. For more details see patient progression chart.

![Diagram of Dutch health care system]

Figure 1. Direction of patient through Dutch health care system.

Availability does not necessarily mean easy accessibility. If a patient wants to consult a Dutch GP, (s)he has to make an appointment commonly done by telephoning the doctor's assistant. The patient has limited decision making unless it is an emergency (as defined by the doctor). At certain times of a day, the patients can visit a doctor during open consultation.
hours (spreekuur). These last generally for one to two hours, twice a day. Consultation time (on appointment) normally takes about fifteen to twenty minutes. However, without appointment during the open hours, consultation time is about five minutes which is highly dependent on the number of patients waiting. For any consultation made with specialists also an appointment has to be made. Depending on the health problem and waiting list, the fulfilment of the appointment plus consultation time varies from specialist to specialist.

It should also be noted that GPs cannot dispense pharmaceuticals apart from a few exceptions. For example, in order to serve the rural areas GPs are self-dispensing. In The Netherlands, without a prescription a patient cannot get medicines from the pharmacy, except mild medicines like aspirin, Paracetamol and homeopathic medicines. GPs prescribe the medicine and refer the patient to the pharmacy (apotheek). It is only opened during office hours, outside these hours a few are open strictly for emergencies.

Health care system back home - the case of Uganda

Notably, when one is across her/his own setting i.e. in another country or community there is a tendency to reflect on one's own background. Reflection is made on how the home society is organised, managed, how it operates and how different it is from the new setting. I will therefore briefly discuss the health care system of Uganda that I am familiar with, as it has been part of me for a long time. This reflection is for comparison purposes with reference to the host country as discussed above in which the foreign students including myself are only temporary residents.

Uganda is situated in the mid-East of Sub-Saharan Africa with a population of about seventeen million people. A contemporary observer could be impressed by the variety of opportunities for health care services. In Uganda, like in many developing countries, health care is provided through a complex network of institutionalised and non-institutionalised (formal and informal) health facilities. Among which include: hospitals, health centres, dispensaries, maternity units, clinics, pharmacies/drug shops, shrines and some spiritual churches. These facilities vary in ownership and legal status. Some facilities are public owned
and others are privately owned by individuals and Christian/Muslim missionary organisations. I will concentrate on the institutionalised health care system.

Availability of curative, preventive and promotive health services is made possible in the health facilities by the assistance of trained medical personnel i.e. doctors, nurses, midwives, paramedical staff, pharmacists and dentists. Originally and officially in the 1960s, medical services were free and of good quality. This was hampered by the political and economic decline in the 1970s. This disruption of the progressive trend led to low medical salaries of about US $ 20 per month and affected morale of personnel and quality of services/facilities. This forced medical personnel to search for 'greener pastures'. In the late eighties and nineties the government has tried to improve conditions among others by introduction of cost sharing in and decentralisation of health units. However, the doctor-population ratio is still high, i.e. one per 28,000 (MoH 1993: 8).

Moreover, very evident still are the economic survival strategies in the health care (Van der Heijden and Jitta 1993). For example, many doctors and other medical personnel in government/public services have one leg in the hospital and the other in private practice in order 'to make ends meet'. In absence of medical personnel in many health units, the family ensures that their patients gets the necessary attention and care (Mpabulungi 1998). For a patient with his or her family around during an illness episode either in hospital or at home there is an added advantage of saving on time (waiting to have treatment), money, and other inconveniences.

Family members can also be of help in selecting a doctor they are acquainted with being a relative, family doctor or friend. Prior information about a doctor is very important in quest for therapy no matter the location as patients are always advised, njia yedokita gumdi aidhadhaba bulungi ... zona neyamponya, (go to that doctor, (s)he gives good treatment ... (s)he cured me). In short, the family is playing an important role in quest for therapy creating a therapy management group not only at home (cf. Janzen 1987) but also in health institutions (Mpabulungi 1995).
Interesting to note, in Uganda medicines are seen as substances having power to transform a condition; as objects they can be detached from relationships and transacted over various geographic and cultural locations (Whyte 1991: 217-233). In view of this point it should be noted that treatment is highly dependent on medicine or injections (Birungi 1993). A lot of medicine is prescribed and dispensed by medical personnel for almost every illness. Actually, I would say this is one way of measuring patients' satisfaction: *without getting medicine the doctor is considered unworthy and his/her services are seen as poor.* Interesting too is that if medicine is not prescribed by the doctor, it is readily available any time, anywhere in the pharmacies/drug shop or any ordinary shop. Even neighbours, friends and relatives have medicines in stock ranging from pain killers to antibiotics. To get it from them, all one needs is the name of the medicine or brand, which is an important aspect of self medication where some people are either ignorant about the dosage or have vague ideas what the medicine is for (Van der Geest & Whyte 1991).

From the above, it will be clear that there are extreme differences between health care services in Uganda (and comparatively elsewhere in 'the South', cf. Van der Geest & Whyte 1991) and The Netherlands. Especially in regard to accessibility to health care facilities patients need not or rarely to make appointments with their doctors. Patients can get all medicine without prescription and if prescribed it is provided at hand. Notably, although affordability and availability of health care is a major problem to many patients, it nevertheless is ensured through the therapy management group (family members and friends). In addition to institutionalised health care alternative health services including folk or traditional medicines are widely used. Therefore, it could be inferred that foreign students come to the Netherlands with home-influenced expectations which are not congruent to the Dutch health care system. To them, the latter seems to be inaccessible, formal and 'impersonal', as it is more bureaucratically organised than in their own countries. It is important to keep this in mind for the rest of the discussion, especially in chapter four. But first lets see what services are in place at UvA and ISS.
Health care services in place for foreign students at ISS/UvA

As mentioned earlier, the Dutch health insurance system ensures every inhabitant of The Netherlands (including immigrants and foreign students) access to health care services. Although this policy is known to everyone, most foreign students have limited knowledge about how the system operates. As I stated above, they carry their own ideas and experiences from home. Of course, this is also known by the policy makers. In order to make the students' stay in The Netherlands easy and 'healthy', assistance in the form of general instructions and information is given to them. Information about health care and medical insurance is included in the booklets, leaflets and brochures which also deal with housing, transport, money etc. given to them before or after arrival. If one saw and read the titles then (s)he could know what I am referring to. For example, Nuffic disseminates the following booklets: A practical guide to living in Holland; An introduction to living in Holland.

I also came across other booklets the two institutions published annually and provided to the foreign students, among which was: Welcome to ISS- a student handbook. This booklet was available at the welfare office. At UvA, due to the fact that it has many international courses organised by different faculties, information was provided to foreign students by different people/centres. Booklets like International students guide Amsterdam 1997/98, 1998/99, Foreign student guide 1997/98, Insurance passport for students (IPS) etc. were provided at the desk of foreign students relations office, UvA. In addition, programme co-ordinators arranged specific hand-books about the course in which health and medical insurance information was incorporated e.g. Amsterdam Masters Medical Anthropology (AMMA) 1997/98; ACCESS 1997/98; and Masters in International Finance (MIF) 1998/99. The information given about health care and medical insurance was a brief description on: family doctors, hospitals, dentists, pharmacies, sexuality, psychological help and emergencies, including all the necessary addresses, telephone numbers. How, then, are these health services institutionally organised?

At ISS, there are six doctors (three female and three male) whom the students can consult in case of any illness episode. The institute selected these doctors on the basis of the following criteria: frequency of consultation by students, patients' satisfaction and location. All these
doctors are GPs with a private practice, either working alone or with a colleague in the same clinic. Not only are the clinics located close to the institute but also close to the students' hostels. Students are expected to make appointments before consultation within stipulated hours of the day i.e. between 8.00 and 12.00 hours. For brief advice (results) and house calls students could consult the doctors on phone but also during specific hours e.g. 08.15-08.45 hours and 12.00-14.00 hours respectively.

In addition to the services provided at the clinics, at the beginning of January 1998 one of the above GPs offered to have consultation hours at the premises of ISS itself once a week on Thursdays between 16.00-18.00 hours. He provides services in one of the rooms in the attic. Students do not have to make appointments since the procedure is first come, first serve, and it is only about three minutes walk from the computer room. For the medical services offered to the students their is no direct payment involved.

Students at UvA are entitled to use the university student medical service. The clinic is located at Oude Turfmarkt 151 near the information computer centre. It is a practice with six GPs (two female and four male) each having his/her own consultation room. The clinic is open five days a week, Monday to Friday from 09.00-17.00 hours. On Mondays and Thursdays between 17.45-21.00 hours the clinic is open due to departmental branch meeting. For consultation, the patients are expected to make appointments between 09.00 and 12.00 hours. Even if one made an appointment there are still some regulations: if one wants to discuss several health related problems during consultation, it may be necessary to make another appointment. If the consultation exceeds twenty minutes, a double consultation would be called for, in conformity with the national agreements. A patient who wants to cancel an appointment has to do it 24 hours in advance. In case of late cancellation or failure to keep appointment, the consultation will be charged.

Open consultations hours are also possible at this practice during specific hours between 09.00-09.45 or 13.30-14.00 hours. Note, during these hours it is not possible to consult the doctor of your choice as a result of limited consultation time. And if the nature of the problem requires more time, the doctor may ask the patient to make an appointment. At this practice
too, house call can be requested for preferably before 12.00 hours or late in the afternoon, in case of an emergency.

It is important to note that all the medical assistance received has to be paid through private insurance. However, for students with E-111 form or those who have bought an International Insurance Passport for Students at the office of the foreign relations there is no direct payment for treatment involved. Patient is required to show the insurance documents before consultation, at the reception desk. In some cases, access to the medical services necessitates payment of 37 guilders for each consultation made, prescription fee not inclusive. This is reimbursed by the insurance company.

Both institutions have organised services for psychological problems i.e. psychologists dealing with depression, motivation or concentration difficulties, difficulties in relating to other people and psychosomatic complaints. For information about the services or appointments, students are expected to call on weekdays between 09.00-12.00 hours. All psychological consultations are considered strictly confidential. There are also dental services organised for the students by the institutions but these are not covered by the insurance company. Foreign students have to foot the bills at times with 10 percent or 50 percent discount on the dental treatment.

Apart from the psychologists, doctor's assistants and welfare officers/programme coordinators play an important role in the provision of health care services to foreign students patients. Below I give a summary of their activities:

**Role of doctor's assistants**

As a patient you can turn to the doctor's assistant for:

- general information
- registration
- making appointments
- explanations about the prescriptions
- reporting changes of address or insurance
- information about payments.
- having stitches removed
- laboratory tests
- administering injections.

**Role of the welfare officer/programme co-ordinators**
- counselling of students i.e. health problems and educational problems
- social guidance i.e. sensitise students how the system works.
- organising social and educational activities during the orientation week
- arranging housing facilities for students
- providing any kind of information or assistance e.g. about doctors, economic problems etc.
- arranging booklets with general information
- assisting in all kind of problems

Now that we have seen how health services are organised, I will explore, on the basis of my fieldwork data, how they are in practice.
Chapter Four

Students' care in practice: expectations and experiences

It is when I fell sick that I actually realised how ignorant I was and how I had underestimated everything. I thought it was just easy but it was not ... Experience is the best teacher, we learn from it...(A student at ISS).

Ill health is a fact of life. Mild or severe, it can disrupt the pattern of daily life not only that of the sufferer, but also the community (s)he is part of. However, one's own experience of an illness episode (ill health/health problem) determines how other people and her/himself perceives and solves the problem. In the above quotation a foreign student remarks that experience is the best teacher.

In this chapter, I describe the health seeking path for foreign students. The first few sections focus on understanding the various ways in which student acquire information about the existing health care services in the Netherlands and how they select the GPs. The sections that follow, specifically look at student's health problems, treatment provided and their general perception towards care received. The section builds upon data collected on the basis of students/GP transactions. Conceptually, I reflect upon Arthur Kleiman's (1980: 207) framework for carrying out cross-cultural comparisons and for collecting ethnographic data on practitioner-patient interaction. In particular, I take into account the following aspects: institutional setting; characteristics of interpersonal interaction (time spent in consultation); quality of the relationship; attitudes of the patients and practitioners; idiom of communication; and treatment expectation. To fully understand the various ways in which students adapt to the Dutch health care system, below I have developed to two case studies built upon concrete illness episodes among students.

Case A

On 29/9/97 a youthful, healthy looking African lady, aged 31 arrived in the Netherlands for a one year masters degree at the University of Amsterdam. By the time of my fieldwork she recalled to have had three health problems—a cold and tonsillitis during winter, and stomach-ache with heavy bleeding a result of an epitopic pregnancy. For these three illnesses she consulted the two GPs.
The first time she consulted a GP was shortly after her arrival in the Netherlands full of joy and excitement of being accepted to pursue further studies. However, her mood was abruptly interrupted when she developed a stomach-ache three days after her arrival (which was a Saturday). First, she thought it was mild condition resulting from change of environment or maybe food poisoning. So, she took some home remedies - strong tea and Paracetamol. Relief was obtained for some three hours and later she experienced some other severe pains. She certainly felt she had to do something, but being in the foreign land she felt helpless. She was in a state of panic and confusion about what to do. She had no information about doctors or hospitals. Besides, she had never anticipated falling sick while in the Netherlands.

Being a stranger and so scared about her health, she sought for immediate help from her neighbour. Fortunately, there was someone occupying the next room; a gentleman who was also going to pursue a similar course. She said, ‘seeing this person at that moment was a great relief.’ In the process of establishing rapport, she felt another sharp pain and immediately asked for help. ‘I have to see a doctor, I think I have developed appendicitis,’ she added. The gentleman also quite new in the Netherlands asked: ‘where do we find one.’ The gentleman then lashed for a telephone book and called for an ambulance. In no less than five minutes, the ambulance was at their door. However, what was most disappointing is that before she could get into the ambulance they requested for her insurance card. Confidently, she pulled out her global insurance card from home, but this was rejected. However, the ambulance staff were human enough to take her to the emergency unit. Here, a urine test was carried out, but neither was she given the result or an explanation and/or treatment. Instead, the health personnel kept on murmuring amongst themselves in Dutch. She sensed that something was very wrong. She was advised to go home and contact a GP. But she had no knowledge of any GP.

At home, the pains persisted. The foreign student residing in the nearby grew concerned about her situation. They provided what was considered ‘strong painkillers’ (Brofen) until Monday. On Monday morning, she contacted the program secretary and explained her problem. The secretary called the university clinic and arranged an appointment for her and in the meantime also arranged for her insurance card. Within two hours, she was at the clinic. The GP diagnosed that she had an epistopic pregnancy which needed an operation. The GP made necessary arrangement for the operation at the hospital. In the course of the day she was able to obtain a surgical operation. Despite earlier disappointments she was very appreciative of the care provided at the hospital. At least she did not have to wait for days to have the operation!

The second time she consulted the GP she had tonsillitis. At the reception desk was a doctor's assistant who asked in a friendly but 'professional' voice, do have an appointment? She replied 'no!' As it was open consultation hour she was registered and asked to wait for turn. She sat there scanning through the Dutch magazines and looking around to see what was going on for about half an hour as their were many people waiting. Reflecting on the clinical setting back home where people were ever chatting, people looked really sick and the environment was full on people one was familiar to. She said the clinic here was the opposite, people are did not look sick, no interactions going on, patients seem impatient and actually the doctor spent around five minutes with each.
On this consultation she was surprised that she had to see a different GP but thought it was the system. She sat down and the doctor asked, so, what can I do for you today? She explained to the GP that she had tonsillitis who later examined her throat and inquired if she had any pain. She responded affirmatively but disappointment arose when the GP consoled her it was fine, it was a simple problem, advised her to buy some Paracetamol, have a bed rest for a few days.

Unlike the first consultation, to her this second consultation was a disappointment. She lamented, falling sick in a foreign country is the worst thing that can happen to you. However, this disappointment was dealt with when she got some medical attention from her colleagues.

Case B

Sujoy, an Indian aged 24 years arrived in the Netherlands in August 1997 to pursue postgraduate studies at the Institute of Social Studies (ISS). I met Sujoy at the waiting room at the institute clinic.

At the beginning of our discussion Sujoy was defensive, stating that; 'generally my health has always been good even before I came to Holland ... apart from the eye problem and headaches that have resulted from sitting at the computer for long hour. Actually I have hardly consulted a GP nor have I experienced cold, flu, stomach-ache.'

The first time that Sujoy consulted a GP was when his eye was watering. At first this was perceived to be a mild problem. He carefully cleaned his eyes on a daily basis for almost a period of one month - but the problem persisted. Rather scared about his degenerating eye problem, Sujoy decided to call his father back home for consultation. Sujoy gave a detailed explanation about his eye problem and the father concluded that it was a bacterial infection. He also advised him to seek professional treatment. The GP was scheduled to visit the Institute the following day. So, Sujoy took this opportunity to visit the clinic.

The doctor examined Sujoy’s eye and explained to him that he had a bacterial infection. Sujoy was so pleased to learn that the doctor’s diagnosis was similar to what his father had concluded. He was prescribed an eye jelly which he to purchase from the pharmacy.

However, Sujoy faced some difficulties after consultation i.e. getting this medicine from the pharmacy. Having assumed that pharmacies were opened until late like back home, he was disappointed to find none open. At the one that was open the pharmacist told him could not get that medicine, as his case was not an emergency. Sujoy left very sad as he felt his problem was an emergency, he could not work with the eye watering. Two days later he managed to get the medicine though according to him it did not give immediate results but with patience the eye problem was solved.

Reflecting on his own setting, to him having medicine at hand or at the counter is important but it is a disadvantage in Holland. Medicine is not readily available yet there are a lot of intervening factors. So foreign students should be aware of this before they come for further studies in the Netherlands. The definition of an emergency should be clear. Despite that hurdle, Sujoy was pleased that he got the medicine and was able to carry on with his study.

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Being a foreign student patient

Before I went to the field I felt that patients react the same on ill health no matter where they are. During fieldwork I gradually became aware that things are different. I asked myself the question: 'Does location influence the way one feels and deals with an illness episode?' Depending on the narratives I had from my respondents, I can now answer it affirmatively.

Ill health generally created a lot of anxiety among the students. Interviews with my informants revealed that illness was normally accompanied by panic, fear and confusion, since this was their first time overseas and/or in the Netherlands. Besides, many barely had enough time to understand the manner in which the system functioned. The questions that seemed to linger in the students mind were:

1. How do I find a doctor?
2. How can I get there?
3. What language should I use?
4. How shall I be received?
5. What kind of treatment will I get?

Finding a doctor in The Netherlands

The Dutch embassies overseas normally provide foreign students with a handbook: Living in Holland. This handbook contain various information, including a few sentences on health care. In addition, ISS, Nuffic and UvA distribute almost similar handbooks to foreign students before or on arrival. The messages (see below) normally provide hints and/or advice to a newcomer to the Netherlands.

When you arrive it will be advisable to choose a family doctor (GP). Have the GP’s phone number and address (and how to get there) ready in case you need it (Blok 1997).
You should enrol with a huisarts as soon as you can, rather than wait until you are ill. It is simple and it costs nothing (Boonstra et al 1996).

If you have a non-critical medical condition, you should see your GP first. It is important, therefore to sign up with one as soon as you have settled in the Netherlands (ISG 1998/1999).

In the Hague, all my informants had an idea of the substance contained in the handbooks and especially so the list of doctors. Their knowledge of the content had been enhanced through the orientation course run by the Institute shortly after the arrival of students. Given the diversity of training programs at UvA, it is not possible to run an orientation course on health care for foreign students. Thus, students are expected to rely upon information provided in the handbooks. The handbooks emphasised the need for students to register with a GP. In addition, the foreign students’ office and the programme co-ordinators/welfare officer provided verbal advice to students with the necessary procedures for registration with a GP. However, unlike students at ISS, many students at UvA commented that information provided was in Dutch therefore incomprehensible.

In the course of my fieldwork in Amsterdam, an attempt was made to elicit information concerning the various ways in which foreign students find their way into the Dutch health system. Here below, I present one interview with one of the students:

Interviewer: Did you find any problem finding a clinic?
Student: Yeah, it was not that easy because I think I got some kind of brochure from the University but the trouble is that it was in Dutch. So I could not really get to read about where to find a clinic. I threw away the brochure. Anyway at that time I had no medical problem. I simply gave up the idea of searching for a clinic.

Interviewer: And did get any information from the foreign students office about the clinic (showing him the brochure from the University clinic)?
Student: No, no, I have never received such information from them.

Interviewer: So, how did you get to know about the clinic, its location...
Student: My roommate told me about it. As I have told you when I went to the clinic, the lady at the reception gave me some papers with the information. She first asked whether I had ever received it. Then I replied no. And she said they send it to the University but...the problem it is in Dutch. They did not know that most foreign student do not speak Dutch. I do not know why it is in Dutch...they should provide something in English.

Interviewer: So...?
Student: Well, there is much information about the GPs, clinics so I guess... but it is in Dutch and a lot of foreign students who have not fallen sick do not know where to go in case they fall sick.

Given the circumstances, at least all students interviewed in Amsterdam chose to informally seek out information from friends and colleagues who had prior experience with the system. Some obtained information by accompanying sick friends to the clinics. Surprisingly, even at ISS where students had access to brochures in English, there was a general tendency to seek out friends for information regarding health care. According them, it was that through friends they had a hint of what to expect of the Dutch health care system. In a small discussion group for instance, one ISS student who had never consulted a GP remarked,

I know where to go when I fall sick. I have been hearing self participants in the hostels advising others. I have a hint how things work. If you do not hear it from your ‘family’ then the friends are there when you need help.

This kind of network among students created therapy management group, this time friends replacing the family as will discussed later. These helped students to get the necessary information. The Diagram below illustrates the existing dissemination channels for health care information.
Choosing a General Practitioner

*You are free to choose any doctor, however, the following doctors are suggested, as ISS generally has good experience with these doctors* (Blok 1997)

The Dutch health care system gives liberty to all consumers to select a doctor of their choice, close to their residence. As discussed earlier in chapter three and the above quotation, both ISS and UvA have made prior arrangements with GPs and therefore provide students with a list of ‘recommended’ GPs from which to choose. These GPs must have exhibited vast experience at handling health problems of foreign patients (asylum seekers, migrants, tourists and foreign workers (staff at foreign embassies and multi-national companies) and must be located within proximity to the institutions. Official procedures do exist for selection of a GP stipulating freedom of choice of GP but only work on paper. Discussions with my informants at ISS seemed to imply that selection or even free choice were not the right concepts to use. To many students choice of a GP was pre-determined by the institute and other factors such as proximity. At ISS, I noted that all my informants consulted a single doctor partly because
his clinic was situated close to the ISS and the students hostel. Secondly, his availability and practice at the institute once a week was an added advantage. To many students, this was indeed time and cost saving. This came up during screening and actual interviews which went on like this,

_Interviewer:_ Have you ever consulted a doctor for any health problem?
_Student:_ Yes, I have consulted Dr. X (name withheld).

_Interviewer:_ What health problem did you consult him for?
_Student:_ I consulted Dr. X three times. The first time I had a headache so I decided to go for treatment.

_Interviewer:_ How did you get to know him?
_Student:_ Dr. X is known to every participant. It is where we go whenever we are sick.

In Amsterdam too, foreign students felt that their choice of a GP was restricted. Here, it was a requirement by the University that students enrol with the University clinic in case of any emergency. A few students who had consulted the clinic commented felt that they had no chance to select a GP of their own choice. The entire selection process was complicated by the fact that during every other consultation they sometimes had to see a totally different GP. One student commented, 'When you visit the clinic there is a receptionist who tells you to wait until your name is called. So, the GP who calls your name is the one you follow for consultation.' When asked why they did not make a selection for a doctor, most students replied that they did not know about the procedures, while others mentioned that they had not thought about it.

A few UvA foreign students residing outside Amsterdam have the privilege to select a doctor. However, just as has been noted in the ISS case, their choice was pre-determined by accessibility. In a related case, one student narrated;

_It is a long story, how things happen... When I came to Holland, I did not think of getting a doctor till I have severe abdominal pains. It was really painful that I could hardly wait to see a doctor. I grabbed the yellow pages searching for the word _huisarts_ and also for a familiar street close to the University. I found what I wanted, called the doctor...I was told to go over... that is how I ended with him. It was quite an experience._
Even on the basis of pre-determined lists of GPs, it was common for students to make their selection or choice after consulting friends and colleagues. Data from both institutions shows that decisions for health care seeking were to a large extent influenced by friends and colleagues. One student said,

I got to know that doctor from my friends. This is the reliable source, my friend coming from the same country and others who had consulted him...I personally do not think of getting another doctor.

In particular, students confided so much in the program co-ordinators and secretaries and acted upon their advise as shown in Case A. It was also noted that before visiting a specific GP students made an inquiry about what to expect. This practice proved beneficial to all the students in the sense that were consulting doctors who were familiar to people they were associated with. This involved accompanying the sick student, making appointments for them and introducing the students to the doctors, later the same doctors became their GPs.

At both institutions gender of the GPs was a minor consideration during selection. This is related to the illness presented as will be discussed below. Of the thirty students only two female students requested for a particular gender, female doctors for the sake of comfort and feeling secure.

**Common health problems among foreign students**

Data concerning foreign students health problems was gathered on the basis of in-depth interviews with GPs, doctor assistants, clinical psychologists, program co-ordinators, welfare officers and foreign students co-ordinators. In addition, a review of records was made at private clinics which were utilised by the students. Overall data shows that perceived or known health problems of foreign students varied from mild/simple health problems, psychosomatic symptoms to chronic illnesses. However, according to key informant interviews with GP, chronic illness and gynaecological problems were rarely presented. The table below present the illness spectrum of foreign students.
Common/mild Psvcho-somatic chronic
Mild viral infection (tonsillitis) psychotic problems
Airway infections Stress related symptoms
    cough sleeplessness
    cold/fever(griep) homesickness
    stomach aches headaches
peptic valve syndrome muscle/joint pains
    skin problems back constraints
    body injuries
Eye problems
gynaecological problems

Table 4: Distribution of health problems

Data obtained from the GPs and doctor’s assistants showed no variation from the in-depth interviews. It indicated that an estimated 70-75% of the health problems fell in the category of mild viral infections and griep. This trend is also confirmed by data collected from the 30 student informants and from the small group discussion. Here it was evident that majority mainly presented simple illness such as cold (flu, fever, sour throat), headache, joint and chest pain and knee problems to their GPs.

An interesting aspect of data on student’s health problems lies in the divergence of description of between the GPs and the students. To some students for example, a rise in the normal temperature was related to an onset of a fever, but to the medical practice however, this was symptomatic of a physical disorder. From the GPs point of view headache is a symptom and not a disease. Generally, students considered mild illnesses to be an indication of something severe, yet GPs simply took these conditions for granted since they were also commonly presented by Dutch patients too.

General Practitioner and students’ interactions

'Booking a doctor'
Interaction between students and GPs normally set off by calling the clinic to fix an appointment. This process was popularly referred to as ‘booking a doctor’. At the end of the
line, there was usually a friendly and professional female voice. Two standard questions that were commonly raised to the caller include: the patient’s family name and date of birth. The doctor assistant screened the computer, checked the doctor’s agenda and later got back to the caller to fix an appointment. Both in The Hague and Amsterdam waiting period was usually for two days. Those with severe and emergent problems receive a prompt appointment. As explained by one student who had a severe cough:

I called to make an appointment, but I was told that the doctor was fully booked. When I explained that I had serious cough an appointment was fixed for the same, though not immediately.

Note, at ISS no student could consult the doctor’s clinic without appointment but there was a visiting GP at the institute. Here, students can consult without an appointment. In Amsterdam, student took advantage of the open consultation hours where they were not required to have an appointment.

The clinical setting

It is a common anthropological view that the clinical setting has an influence the doctor-patient interaction (Kleiman 1980). Certainly to many of my informants, the clinical setting in Netherlands was quite different from that of back home. In particular, the mandatory requirement for an appointment and insurance card or number before consultation came as a shock to many students.

Waiting time before consultation varied between ten to thirty minute and was influenced by the number of patients and duration of consultations. Some students found it strange that patients hardly talked to each other; instead they read magazines, newspapers, notices, leaflets and brochures. The quite atmosphere surrounding the waiting was a source of discomfort. As remarked by one student: ‘I felt lonely and out place in the waiting room’.

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Nevertheless, in terms space and privacy the waiting room was considered just right. The staff looked busy but also friendly—once in a while they had eye contact with the waiting patients and sometimes managed to smile. What also seemed strange is that unlike situations back home where waiting patient appeared ‘real’ sick, in this particular case patients ‘did not look sick’. I suppose partly because back home patients visit clinics in support of the families and sometimes friends.

**What happens in the consultation room?**

Consultation normally lasts five to ten minutes depending on number of waiting patients and by the fact that open hours for consultation were only meant for those urgent problems that could be dealt with immediately. In case a patient required extra consultation time, the GP advised that another appointment be made. Consultation time for patient with appointment was much longer, normally covering a period of ten to thirty minutes. Patients were also sometimes to make a follow up appointment.

The strict time management practice and a rather restrictive consultation was a major source of complaint among several students. In contrast, back home GP (private doctors) were available and accessible for the entire twenty four hours. Appointments did not really apply. In situations where the doctor was not available, the patients were free to make a home contact or even ‘shop’ around for alternatives. Some students also commented in their countries patients were not tied up with consultation time—they had the liberty to fully interact with the doctor.

However, the GPs were on the whole considered polite and friendly. They applied a personal approach; they greeted their patients, shook hands and took much concern at understanding the patient’s background (country of origin, occupation back home and in the Netherlands, duration of stay, religion, marital status and children if any). A GP in The Hague pointed out that it was important to ease the tension of the patient, reason being:
For every patient it is normal to be afraid if you do not know a doctor. So, if someone comes to my practice, I will immediately invite him/her to discuss a few things concerning his/her medical history. I have to get to know the patient and the patient has to get to know me too. I tell him/her that it takes a few contacts before you know whether you are comfort with each other.

The doctors were also courteous, in the sense that whether the patient spoke Dutch or not. This was followed by an inquiry into the patient's medical history. Here, emphasis was on finding out whether the patient had any chronic illnesses, hospitalisation history, surgical operations and medicine use history. Generally, students appreciated with approach which they said made them feel at ease. Most students were also pleased by the idea that the GPs spoke simple and clear English. However, some students at UvA complained of having had language problems and felt neither the doctor nor themselves were fluent enough.

Discussions about illnesses are normally set off with one come question: 'So, what can I do for you today'. This approach was not much different from what foreign student have experienced back home. Students generally presented their complaints symptomatically. They also linked their ill health to a reduction in their capacity to attend lectures or write up their papers. The students commonly expressed themselves in this manner:

I have cold and pain all over the body ... I feel weak, fever, stomach pain... I can enjoy my food, I can eat or sleep or do anything...I have backache, it is painful and sharp...I have difficulties in reading.

Yet others metaphorically expressed their illness-one student presented her illness in this manner:

I felt like someone had knocked me, I could not work on the computer. I could not bend my knee or walk normally.

It is on the basis of such explains that a GPs tried to establish the disease aetiology. For purposes of clarity, GPs went further to inquire about how the pain occurred or whether the
patient had ever experienced a similar problem. Depending on the patient’s response, the GP
would then decide whether further examination was necessary.

Perceived quality of care

Data on perception of quality of care was gathered on the basis on observations of clinical
encounters between student and the practitioners. This was supplemented by data collected using
in-depth interviews among students and small group discussions. In Amsterdam and The Hague,
the informants dichotomised quality of care into interaction/diagnosis and treatment.

1. Interaction/diagnosis

Overall, data suggests that most student received ample attention from the practitioners.
Students considered doctors to be friendly, polite but also professional. The GP too
considered the students polite, friendly, open, frank and less assertive than the Dutch people.
According to the practitioners, it was a professional requirement to show concern to the
patient as this enhanced communication between them and their patients. The practitioners
normally examined the patients and touched them. However, a major communication problem
was the discrepancy between the students’ and doctor’s explanatory models of disease and
treatment. It is here that most students expressed dissatisfaction with the Dutch health care
system. Here below, I produce an extract of a student/doctor interaction.

Doctor: (moving the leg up and down, left and right holding the knee) Does it hurt
when I move it like this? (doctor listening and observing the way she was talking).
Student: It really hurt yesterday, today the pain is less. I could not bend it.
Doctor: Do you sit and work so long on the computer?
Student: No, not really...
Doctor: Do you sit on the floor with your legs crossed? As it is not good for the
knees...
Student: No, I do not know what happened.
Doctor: Well, ...(writing a prescription) I think there is problem with the tendon
and cartilage. You will be fine.
Student: But doctor, it hurts. Do you think I will be okay soon?
Doctor: (looking at her) well,... I prescribe you some Paracetamol. You can take
it when the pain is severe. The pain will go but it persists you can come back.
Student: (seeming a little disappointed) Thank you doctor.
Doctor: (shaking hands and opens the door for her ) You are welcome. See you.
The above extract provides a picture of a varying explanatory models between the doctor and the students. Although, the patients seems appreciative of the doctor’s concern and care, she also felt dissatisfied and doubted whether the treatment provided will solve her problem. The tendency to prescribe a pain killer by most of the practitioner seemed also a source of dissatisfaction among students. As one student remarked, ‘You have to show that you are sick. Otherwise you will not get any medication’. In yet another related experience one informants complained:

The doctor said I was stressed. I was amazed and had to laugh since I could not believe it. Maybe it is my background. We deals with stress internally—normally through medication and by consulting our own people (family). Besides, I find stress too simple an explanation for my purpose of visiting the clinic.”

Evidently, there was a variation between the patient and GPs explanatory model for ill health. In this particular case, it appears the student concluded that the GP did not understand what he was suffering from and was trying to simplify and wrongly concluded that he had stress related symptoms. Overall, students blamed GPs for having a general view about foreigners—that their problems were in most case related to being away from home therefore stress associated. They also complained that GPs tended to ignore their physiological problems by merely drawing them to psychological problems.

Concerning explanation, twenty students and other students in group discussions felt that GPs in the Netherlands were unnecessarily too open and direct. For example when a psychosomatic case was diagnosed, GPs did not take sufficient time to prepare the patient. The instead presented the diagnosis immediately, without any holding back. Perhaps, this is a clear case of communication difference between GPs in the Netherlands and GPs in the south. Openness seems to be a principle in the Dutch health care system, whereas back home in a country like Uganda discretion about the patient’s diagnosis is emphasised.

Having heard and told the existing perception of the diagnosis, I tried to find out what GPs and students did in order to fulfil their needs. One of the solutions by students was to show the GP that they were really sick in order to receive some treatment. This was adapted by
many students who they went back for further consultation. Especially so when thought the
doctor neither understood them nor took the problem seriously before. They also gave more
detailed explanation about the illness, defined the illness, cause and asked for the treatment
they wanted. Hearing from friends that they were planning to see a doctor, they told them
how things are going.

On the other hand, the GPs felt that the student patients gave enough details of their problems
which made the diagnosis easy. They too expressed their concern about the limited time for
consultation i.e. they really felt need for more time to discuss the diagnosis and treatment,
especially the issue of prescription of less medicine.

2. Treatment

After one or more consultations, some students got the treatment they wanted, thus, a cause
for satisfaction. However, there was a general dissatisfaction among students at ISS and UvA
about treatment and medication provided. On the whole, qualitative data shows that majority
of students did not receive what they expected. They did not receive any prescription, instead
the GPs provided advice on stress release, eating habits and consolation. As one of the
students who was given advice instead of medicine for her cold expressed her disappointment:
'Even my grand-mother could have told me to do that!

On rare occasions patients were given medicines. Those students who managed to receive a
prescription also complained that what was prescribed is not what they expected. This
complaint was put forward by three quarters of the students interviewed. Generally, students
expected GPs to be prescribe medicines that could offer immediate relief, but they in most
cases disappointed to receive mild pain killers such as Paracetamol or Aspirin, and mouth
wash for sour throat. One female student explained; ‘I visited the GP with a tonsillitis
problem, my throat was examined and I was asked whether I had any pain. I responded
affirmatively, but to my disappointment the GP just told me that I will be fine, and that what I
had was a simple problem. I was advised to buy some Paracetamol and take a bed rest for a
few days.’ In one small group discussion at the ISS, students commented: ‘we always take
Paracetamol without doctor’s advice. We do not to go to them for that.’ From the
discussions, it seemed clear that students and GPs rarely discussed previous medication use.
Discussion with GPs confirmed their need not to prescribe medicines. They stated that although they prescribed medicines, they did this rarely and sometimes on request. Besides, in the Netherlands, there is the general idea that medicines are poison. Something they would only recommend for the seriously ill and not for the minor ailments that foreign students normally presented. When GPs were asked which drugs they would prescribe, they mentioned that they were more inclined to prescribe pain killers than antibiotics. They felt that if antibiotics were used to treat infections in the early stage or too quickly there was a danger of them becoming resistant to bacterial infections. There was also the another danger of spending lot of money on unnecessary medications.

In addition, the GPs were aware that students came from countries where there was a 'pill of every ill.' However, this was no ground for them to over prescribe. In fact, the GPs commented that most foreign students who presented an infection case normally requested for antibiotics. In most instances, the GPs did not positively respond to the request since in almost 90% of the throat infections were viral related. It was also noted that students had presented a sequence of cold, soar throat and cough; which in winter were considered typical viral infections. Thus, it was only a normal practice for GPs to advise all their patients to wait for a few days, buy some Paracetamol and gargle with salt. If no improvement occurred, then one was free to consult a doctor.

Otherwise, those few student who had a chance to receive a prescription experienced some setbacks. A number of students regretted their inability to understand the dosage of the medicines since the labels where in Dutch. In comparisons to drugs consumed at home, many of the drug prescribed were unfamiliar brand, which made some students doubt their effectiveness. Yet some students experienced problems in locating a pharmacy—they were used to the situation back home where medicines are readily available at the private clinics or shops and health units. The process of locating a pharmacy was considered cumbersome. Most pharmacies are open during working hours when students are taking classes. Those that were open after normal working hours only dealt with emergency case. One student explained;
I went to the *apotheek* after six o'clock with the hope of getting medicine. Unfortunately it was closed. I was advised to go a particular that open was open. But when I arrived there, my request for medicine was turned on the pretext that my condition was not serious or urgent. My eye was watering down. I felt it needed urgent attention, since I had to read my books ... this a disadvantage of the Dutch health care system.

Therefore, it can be concluded the perceived quality student/GP relationship is good. As already shown above attention extended to foreign students at the clinics is good-GPs are considered polite, warm, concerned and also professional. However, there is a general dissatisfaction among students concerning explanation, diagnosis and treatment. This perception seems to be shaped by the different and exotic clinical reality that students found themselves in (Kleiman 1980: 207). Here, we notice that the students' disease etiological explanations sometimes differ from those of the Dutch GPs. Similarly, it was observed that foreign students and GPs do not share the same therapeutic expectations. The need for a "pill for every ill" seemed to be common among all foreign students.

In addition, the GPs were aware that the students came from countries where medicine is used for almost every illness. However, giving them a chance to ask for the medicine they wanted did not guarantee getting it. The GPs interviewed in Amsterdam and The Hague said that most students requested for antibiotics whenever they had an infection. Unfortunately, these were not prescribed to them as they had mainly viral infections. One of the GPs further explained why antibiotics are rarely prescribed. This is due to the fact that 90 percent of the throat infections are caused by virus. In cases of tonsillitis, which could be bacterial, one needs antibiotics. But in sequences of cold, soar throat and cough especially in winter, this is typically a viral infection, where Dutch patients are usually advised to wait for a few days, buy some Paracetamol and gargle with salt. If no improvement occurs, then one can consult a doctor.
Getting located in the Dutch health care system: students' adaptation strategies

Through small group discussions and in-depth interviews with students, I tried to establish the various ways in which students dealt with their unsatisfied health care expectations. Conceptually, students adapting strategies are conceived within the framework illustrated in figure 3. Among the many of coping strategies, carrying from home was most evident. Medicines carried from home countries are usually incorporated address emergent health problems but also to fill the expectations of those students who had not received a prescription from a GPs as expected. This tendency is also confirmed by data gathered from group discussions. Here, students revealed that they stocked up a variety of medicines before coming to the Netherlands.

Out of thirty students interviewed, twenty-seven (ninety percent) stocked up drugs from their home countries. Table 5 below covers a list of medicines that students carried from home. Student felt that it was important to have carried medicines from home since they were not familiar with the Dutch health care system, some wanted to continue using familiar medicines, yet others had stocked up for purposes of self medication in case of any illnesses. During my stay in the Hague and Amsterdam, I noticed that a number of friendly interactions among students covered issues related to illness and sometimes exchange of medicines (Case A and B). It was interesting to note that students asked friends from the same country or continent for medical advise and medication. It was also uncommon to learn that students received parcels of medicines from home.
1. Pain killers for headache, stomach-ache, chest pain, muscle pains
   - Paracetamol
   - Aspirin
   - Asafen
   - Voltarine
   - Brofen
   - Indocid
   - Magnesium triscilicate
   - Chinese medicine/herbs
   - Homeopathic medicines
     - Cabal
     - Anasin
     - Zuber 200

2. Anti-cough, cold
   - Multivitamin tablets
   - Vitamin B complex
   - Nasal drops/spray
   - Pritons
   - Calcium, D Redoxon
   - Vitamin capsules
   - Homeopathic medicines-balm, vicks

3. Antiseptics
   - Dettol
   - Dwarf

4. Other drugs
   - Anti-malarial - Fansider
   - Antibiotics - Septrin, Ampillicin
   - Aldomit

| Table 5. Medicines carried from home |

Almost all foreign students who experienced ill health while in the Netherlands regretted being detached from their families whom they considered a crucial source of support in sickness and in taking major health seeking decisions. As reflected in one student's remark; 'falling sick in a foreign country is the worst thing that can happen to you.' Given such circumstances students cannot need to help one another. They have formed a network around which they can help out each other in circumstances of ill health. The network is composed of fellow foreign students; and provides support, advise, medicines and normally accompany the sick student to the GPs. In many ways this form of network is quite similar to what Janzen (1978) described as the 'therapy management group.' In both Africa and Asia the locus of responsibility for care lies
on the family (Janzen 1978; Whyte 1992; Nichter 1989). It is therefore interesting to note that in both the ISS and UvA the network of foreign students got re-defined into a ‘new family’ that plays a key role in health care. I observed that even in situations where the ill students had not notified fellow students, there was immediate concern—they offered support in terms of preparing a meal, providing some home remedies or medicines, providing medical advise, arranging an appointment with a GP, and accompanying the patient to the clinic. Most importantly, they provided emotional and socio-psychological support directed at quick recovery and successful completion of their study program.

However, some students have devised different adapting strategies. As illustrated in Case B above, some students cannot simply make health care decisions without their families. In such case, the strategy has been to rely on the telephone-call families back home for consultations about how to deal with their health problem. This might sound strange and costly but I have personally tried it. I commonly suffer from allergy and when I came to Holland my situation worsened. On several occasions I wrote and called home asking my sisters to contact my family doctor for some advise and medicines.

Another common strategy was that of showing the GP that they were ‘really sick’. Here the approach applied by students was to insist on a subsequent consultations with their GP. This was particularly useful to those students who thought that the GP neither understood them nor took their problem seriously. The tactic was to provide the GP with a more detailed explanation about the illness, define the illness, cause and sometimes went to the extent of suggesting a certain treatment. Indeed, some students confirmed that this strategy worked.
In this chapter I have examined the expectations and experiences of both students and GPs. These can be visualised as follows in the figure below.

**Figure 3. Quest for therapy by foreign student patient**
Chapter Five

Conclusion and Recommendations

I was inspired to carry out this ethnographic study both by academic and practical reasons. It is meant both for researchers as well as health policy makers and providers to acquaint themselves with what foreign students are actually doing to cope with health problems while in the Netherlands. I felt the desire to bring out this long neglected category of foreigners by grasping their experiences in relation to the Dutch health care system. The anthropological intrusion in dealing with foreign students in the Netherlands in whatever aspects of their lives has been retarded by common assumptions that since they are staying here for a short period and are well educated, they find their ways within society easily and generally have no health problems. In addition, policy makers have put more emphasis on the educational related services provided rather than their health.

In the final analysis, in reference to the studies that have been carried out globally, the notion of improving the health and health care of foreigners or ethnic minorities is pervasive (Bollini & Siem 1995; Colledge 1986; De Haan 1996; Spruit 1987; Venema et al 1995; WHO 1993). In the Netherlands, although it is clear and evident that there are a number of foreigners from all over the world, most publications on health and health care tend to provide information on a macro-structural level. The actual users at the micro-level are more or less viewed in a 'holistic' perspective, as if each category of people would have similar health problems and needs. Moreover, most of the emphasis has been put on migrants and asylum seekers.

I carried out this study as follows. I chose to concentrate on two educational institutions with the highest amount of foreign students: ISS and UvA. To get acquainted with the students' lives at the grass-root, I have participated in their affairs and activities in daily life, those related and unrelated to the objective of my study. Thereby, I have witnessed and observed students' health problems, procedures and intervening factors/problems in their quest for therapy. It is unfortunate that I could not grasp the students experiences during an illness episode over a long time as I would have wished, due to the short field period of six weeks.
However, with due course I acquired more understanding of one being a foreign student patient.

Being a foreigner is one thing and being a foreign student patient is another thing. Like many other foreigners abroad, being away from your own cultural setting is not easy, as many students put it. Reason being that there are so many things one has to adapt to, like the way in which the society functions, the roles and norms of interaction. When a person travels to unknown or unfamiliar territory, (s)he becomes a stranger, at times nervous, irritated and uneasy with the people (s)he meets. This is what Land and Bhahat (1996) referred to as culture shock. A situation when people lose grip on their lives because all familiar things from home are omitted in the new setting.

Foreign students could go through a similar shock: uncertain when still at home, when they are here and when they are about to go back. In the initial stage students are in rapture, full of excitement to leave their homes and ready to build a career. Reaching the Netherlands confusion and feeling out of place are mixed up with the excitement. Faced with the hectic study programme they try to settle down and carry on with the new life, identifying and appreciating the new setting. However, at the time of understanding how things are and feeling more comfortable, the study programme comes to an end and they have to return to their own countries, starting the curve all over again with the same aspects in mind.

It is easy to understand that falling sick in a foreign country make things even worse. Illness being a discomfort generally, abroad it is even more threatening because the patient is not aware of how to seek for health care. Moreover, patients bring their home influenced expectations. From a case study of the health care system in Uganda I concluded that among the study population these were not congruent to the Dutch system.

To tackle this, UvA and ISS were providing information for their foreign students. However, this study shows that due to language problems and limited information students considered it inadequate. At UvA furthermore, faculties were scattered. There was no central programme of introduction, nor a central point of information.
Students, therefore, relied heavily on informal knowledge provided by friends and colleagues who had experience with the system. Students considered this to be one of the best ways of getting information not only about where to find doctors, but also how to select and getting in touch with them. Consulting a doctor was considered cumbersome. Especially the procedure of making appointments was unfamiliar to them. It was commonly referred to as 'booking a doctor'.

At ISS, the doctor most selected had a private practice at the institute. At UvA, GPs worked in a joint practice in which students could consult any doctor. Since most of the students were not aware of the procedure of selection at the clinic, they ended up consulting a different doctor at every visit.

During consultation, students encountered other problems. Although they generally appreciated the doctors' reception and interaction, they found the explanations and diagnoses at times too simplified. According to the GPs the health problems of students at ISS and UvA varied from mild/simple, psycho-somatic related symptoms to chronic illnesses. Chronic diseases and gynaecological problems were rarely diagnosed. There were no gender differences. GPs tended to diagnose students to be suffering from psycho-somatic related problems rather than physiological. This left patients dissatisfied, resorting to an attitude of showing that you are 'real sick' as one of my respondents pointed out.

Furthermore, since they were rarely given medications or treatment, but mild medicines or advice directed at stress release, they either made another appointment or used alternative therapies. Among these were self-medication, calling home for medical advice, and consulting friends. In absence of the family which is the therapy management group back home, the latter took over this expected role.

Having explored how foreign students at ISS and UvA coped with their health problems in The Netherlands, it could be concluded that they encounter various problems. This originates from information and services which cannot satisfy the students' expectations. Although there are differences in health care set-up at UvA and ISS, they do not significantly affect students expectations and experiences during illness episodes.
To help improving this situation I will now present some recommendations.

- Since knowledge is power, it is advisable to pay more attention to provision and dissemination of information in a language which is common to the students (i.e. English).
- It would be advisable to include other forms of physiological and psychological disabilities on medical examination for students.
- In the orientation programmes, more emphasis could be laid on explaining the do's and don't within the Dutch health care system.
- In the orientation programmes, students could be shown the actual places of health care. It could also be helpful to introduce the providers personally to the students.
- Since the courses are considered to be very hectic, it would be advisable to introduce sensitisation workshops, in which students can exchange their experiences in their new setting. Not only among themselves, but also with Dutch people, e.g. program coordinators, welfare officers, psychologists and students.
- During consultation, more time could be invested in getting to know the patient's background and history to avoid generalisations.
- During consultation, GPs could improve patients' satisfaction of interaction by reckoning with the norms of interaction within the patients' cultures, e.g. not being too open and direct.
- Patients' satisfaction of diagnosis could be improved by giving them more detailed explanation about the diagnosis and reasons for rare prescription of medicine.
- As far as treatment is concerned, GPs should be more aware of students' use of self-medication before and after consultation.
- Health providers, policy makers and educational institutions in general could learn from the roles played by the therapy management group of friends and fellow-students in quest for therapy and general welfare.
- Further research could be recommended on the following subjects: pharmaceutical product use, the role of the therapy management group, doctor-patient interaction in a clinical setting and patients satisfaction.
### Abbreviations

<table>
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>ISS</td>
<td>Institute of Social Studies</td>
</tr>
<tr>
<td>ISG</td>
<td>International Students Guide</td>
</tr>
<tr>
<td>LHV</td>
<td>Landelijke Huisartsen Vereniging</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NHG</td>
<td>Nederlands Huisartsen Genootschap</td>
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<tr>
<td>Nuffic</td>
<td>Netherlands Organisation for international co-operation in higher education</td>
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<td>UvA</td>
<td>University of Amsterdam</td>
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### Appendix 1

#### Student respondents

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<tr>
<th>Students from UvA/ISS</th>
<th>Age</th>
<th>Sex (F/M)</th>
<th>Continent</th>
<th>Country</th>
<th>Duration of study (months)</th>
<th>Number of consultations</th>
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**Table 2. Demographic characteristics of student respondents.**

Note that I gave the thirty informants identification numbers: 1 to 15 were students at UvA and 16 to 30 students at ISS.
Appendix 2

Questionnaire A - Foreign Students

Introductory remarks:

I am __________ from _______

Purpose of the study
Aim of the interview
Duration of interview
Any questions?

Background Information

Place of residence (city):
Sex:
Institution/university of study:
Religion:
Continent/country of origin:
Duration of course: _________ months
For how long have you stayed in the Netherlands? _________ months.

History and treatment of health problem

Have you had any health problem while in the Netherlands?
If yes, probe

- What kind of health problem?
- For how long did you have this health problem?
- What did you do when you got this health problem?
- Kind of treatment used
- Effect of the treatment used
- Did you have a similar health problem before? When?

Accessibility to health care facilities

Have you been to any health care facility ( clinic, pharmacy, hospital) in the Netherlands?
Probe:

- Specify health facilities(y) visited
- when?
- Purpose for visit
- Frequency of visit
- What inspired you to go there?
Have you been to or consulted a General Practitioner (GP) while in the Netherlands?

- When?
- Where does the GP operate from? (Specify)
- Criteria of selection of GP
- Purpose for visit or consultation
- what inspired you go there?

Consultation

Could please explain what took place when you went to the GP?
- Did you make an appointment or go during open hour consultation? Why?
- Requirements before consultation (insurance, date of birth, payment of consultation fee);
- Time one has to wait for seeing the GP
- What did you while in the waiting room?
- Duration of consultation
- Doctor-patient interaction (explanation)
- Diagnosis/treatment given
- Any advice given after consultation.

Patient's satisfaction

Were you satisfied with the services and treatment you received?
- Did you get the treatment you wanted? Give reasons for your response

If you had another health problem would you consult the same GP?
Why?

Are there health problems that you feel would not necessitate you to consult the GP?

Please list them.

- Why and when would you not consult the GP?
- What would you do then to solve the health problem?
- Did you carry any medicines from home? Which ones? For what purpose and why?
- Do you seek for any medical help from other foreign students?
- Which people do seek from this help?
- What kind of medical help?

Do you have any idea about what do other foreign students do when they have a health problem?

- Whom they consult first?
- Do they discuss or get advice about the health problem from each other
**Information about health care facilities**

How did you get the information about the health facilities and GP in the Netherlands? (Explain)

- When did you get this information?
- From where/whom?
- Is it readily available?
- From where does one get this information?
- Kind of information provided e.g. booklet, brochures, leaflets, verbal
- Is there a criteria (like making an appointment, proof that you are a foreign student, particular time) for availing this information?
- Language in which information is given.
- Is the information clear
- Is there any additional information given?

Where you satisfied with the information you received? (Explain)

Did you encounter any difficulties getting information about the health care facilities/GPs? (Please, explain)

**Payment arrangement for health care services**

Do you have any ideas about how payment of health care services is done?

Did you incur any expenses for treatment?
- How much?
- What did you pay for?

Do you have an insurance certificate?
- When did you receive it?
- Whom did you receive it from?
- For how long are you insured?

What does your insurance cover? Please, give a brief description
- Do you think there is something it does not cover?
- Do you understand how you are to use it?
- Did you receive any information or explanation about how to use it?
  (Explain information received, from whom)

Have you used your insurance certificate since you arrived in the Netherlands?
- What did you use it for and when?
- If a foreign student is not insured, do you have any idea how he/she caters for the expenses for health care services?
Dutch health care system

Can you please mention some of the things you like and dislike about the Dutch health care system and why?

Are there any suggestions you would like to give about the Dutch health care system in relation to foreign students?

Thank you for co-operation and accepting to participate in this study.
Appendix 3

Questionnaire B - Foreign students

Introductory remarks:
I am ________ from ________

Purpose of the study
Aim of the interview
Duration of interview
Any questions?

Background Information

Place of residence(city):
Sex:
Institution /university of study:
Religion:
Continent/country of origin:
Duration of course: months
For how long have you stayed in the Netherlands? ________ months

Consultation

1. What did the doctor say was the problem?
   - Did you understand what he/she explained to you?
   - Could you please explain what he/she said?
   - Duration of waiting before seeing the GP
   - Difficulties in communicating to GP
   - Duration of consultation
   - Any advice given after consultation

Satisfaction of care

2. Were you satisfied with the diagnosis and treatment obtained?
   - Did you get the kind of treatment you wanted from the doctor?
     Please, explain kind of treatment

3. What did the doctor tell you to do after consultation? (Please explain)

4. If your health does not improve after taking the medication, what do you plan to do?

5. If you could change one thing about the care here to make it better for patients, what would that be?
Appendix 4

In-depth Interview Guide for General Practitioners (GPs)

Introductory remarks:
I am from __

Purpose of the study
Aim of the interview
Duration of interview
Any questions?

Background information

- How long have you been practising as a General Practitioner (GP)?
- What kind of training does one have to go through in order to become a GP?
- How many GPs are working in this clinic?
  Probe: criteria selection to work in a clinic.
- How long have you been working at this clinic?
  Probe: have you ever worked in another clinic?
    Reasons for transfer?
- Could you please give a brief description of your daily activities?
  Probe: Time spent at the clinic
    Kind of health problems she/he deals with.
- How many patients/clients do you see annually? Weekly? Daily
  Probe: criteria of selection of clients
    origin of patients(Dutch/foreigners)

If had experience with foreign students

- For how long have you been dealing with foreign students?
  Probe: Number of foreign students and origin
- What kind of health problems do they present when they come for consultation?
  Probe: common health problem, severity of problem
    Are there any gender specific health problems, which ones?
- How often do they come for consultation?
  Probe: Is it on appointment or open consultation hour? Reasons
- Do you find any problems in dealing with patients who are foreign students? (Explain)
  Probe: difficulties in communication, expected medical services, explanations given/needed.
- Are there any perceived differences between foreign students (Africans and Asians) and Dutch students?
  Probe: communication, expected medical services, explanations given/needed.
- Are there differences between foreigners in general and foreign students?
  Probe: communication, expected medical services, explanations given/needed.
- Do you think that foreign students expect a specific treatment from you?
  Probe: what kind of treatment?
    why do they feel this way?
- Do you discuss with the patients whether they are using any other medication? (non
biomedical/self medication)

- Do you have any suggestions to improve the relationship of GPs and foreign students?
- Is there anything else that we have not covered that you would like to discuss?

Thank you very much for all the information you have given me and your cooperation.
Appendix 5
Clinical Encounter Observation Form

Identifying Information

Name of clinic: 
Date: 
Visit ID: 
Patient Age: 
Time of visit: 
Sex: 

Location

Is there a sign post for the clinic? 
1. Yes 
2. No 
(Describe where it's located)

Description of clinical set up (reception desk/room, the waiting room, examination room, consultation room, toilets, laboratory):

Number of people (gender distribution) at the reception: 

Number of doctors/nurses/assistants (gender distribution) at the clinic: 

Registration

Yes 
No 
Friendly conversation? 
Difficulties in communication? 
Requirements before consultation 
(appointment, insurance)? 
List requirements before consultation:

Waiting room

What does the patient do while in the waiting room (reading a magazine, newspapers (the language used in the texts), any interaction among patients?)
How long does the patient wait before consultation? ______ minutes/hours

Does the patient seem impatient? 1. Yes 2. No

What is the procedure of consultation?
Call patient
Use numbers
Use queue first come first serve.

**Consultation room**

What is the sitting arrangement in the consultation room?

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<tr>
<td>Medical equipment available</td>
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<tr>
<td>(examination bed, stethoscope, BP machine)</td>
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<tr>
<th>Doctor-patient interaction:</th>
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<tr>
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<td>Patient greeted doctor?</td>
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<td>Patient encouraged to describe problem freely?</td>
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<tr>
<td>Doctor listened to responses?</td>
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<tr>
<td>Encounter ended abruptly</td>
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<tr>
<td>Patient appears to want more information?</td>
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**After consultation**

Where does the patient go?

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<th>Is there any advice given to patient after consultation?</th>
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**Observer notes and comments**

(non-verbal expressions such as smile, touch, tone of voice; eye contact between doctor and patient; language used; advice given to patient; questions posed by the patient; how doctor ends the interaction).