

**“We expected paradise”:
Iraqi immigrants’ perceptions and
experiences with healthcare in Norway**

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Abstract

"We expected paradise": Iraqi immigrants' perceptions and experiences with healthcare in Norway

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Cultural competence has been demonstrated to be of great importance in the delivery of quality healthcare to immigrants. Iraqi immigrants experience a high burden of illness; however, little research exists regarding this group's interactions with the healthcare system. Thus, we aimed to explore Iraqi immigrants' perceptions and experiences with Norwegian healthcare.

We conducted 20 in-depth interviews and one group interview with Iraqi immigrants in the greater Oslo area. Interviews were analyzed using Systematic Text Condensation. We also carried out 15 informal key informant interviews.

We found that Iraqi immigrants generally evaluated Norwegian healthcare positively, compared to healthcare in Iraq. In-depth interviews with Iraqi immigrants revealed the following experiences with Norwegian healthcare: unmet expectations; distrust toward general practitioners; and perceived differential treatment, substantiated by concrete examples of differential treatment. However, respondents hesitated to voice criticism toward healthcare providers. We also identified several barriers to care, including intimate partner violence, inadequate provision of trained interpreters, limited health literacy, language gaps, and cost of outpatient care. Social support through advocacy and provision of information facilitated access to care.

Despite generally viewing Norwegian healthcare positively, Iraqi immigrants are subject to multiple barriers to care, including language gaps and inadequate provision of interpreters. Concrete examples of differential treatment in healthcare settings emerged; yet, participants hesitated to voice criticism, which may be partly explained by "The Happy Migrant Effect." As perceived differential treatment was exacerbated by unmet expectations, divergent past experiences, and limited health literacy, efforts to reduce perceived differential treatment ought to include provision of adequate information and discussion of patients' expectations, particularly in the establishment of GP-patient relationships.

Publications: One article has been submitted for publication in BMC Health Services Research on the basis of this research project (See Part II).

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Abbreviations

ER	Emergency Room
GP	General Practitioner
NIS	National Insurance Scheme (<i>Folketrygden</i>)
RGP	Registered General Practitioner Scheme (<i>Fastlegeordningen</i>)
SSB	Statistics Norway (<i>Statistisk sentralbyrå</i>)

Operational definitions

Migrants: A broad term referring to persons who have moved from one country to another, on either a temporary or permanent basis. This term does *not* apply to tourists or students.

All of the following definitions correspond with Statistics Norway definitions¹.

Immigrants: Persons who were born abroad to two foreign-born parents, and who have moved to Norway.

Norwegian-born to immigrant parents: Persons who were born in Norway by two immigrant parents.

Persons with immigrant backgrounds: A broad term of immigrants, including, but not limited to foreign-born with one Norwegian-born parent and Norwegian-born with one foreign-born parent.

Refugees: Persons who, according to the Norwegian Directorate of Immigration's register of refugees, have refugee status and have been granted a residence permit in Norway.

Persons with refugee background: Persons who have fled to Norway, including their family, but not their children born in Norway. These persons have not necessarily been granted refugee status from the Norwegian Directorate of Immigration.

Iraqis: Persons born in Iraq.

¹ http://www.ssb.no/innvandring_en/

As international research does not comply with these definitions, the terms “immigrants” and “migrants” are used interchangeably when referring to international research. However, the study population was strictly defined according to these operational definitions, as described in chapter 4.2.

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PART I: Monograph

Chapter 1: Introduction and Literature Review

1.1 Introduction

This monograph is intended to supplement a scientific article that has been submitted for publication to BMC Health Services Research. Though the article stands on its own and will be judged by its own merits, our hope is that this monograph can be a helpful tool in further contextualizing the findings, analysis, and conclusions made in the scientific article. In the following chapters we will provide an in-depth presentation of the context and rationale for the study, as well as a detailed outline of our methodological approach and the ethical issues that we faced.

Please note that, as this was not a theoretically driven study, theoretical and conceptual frameworks are given limited attention in this monograph. Moreover, given the primarily inductive research design, the scope of the literature review is narrow. Still, we believe we have addressed some of the most relevant theories and empirical findings to sufficiently locate our study within existing bodies of literature.

As this thesis is in large part a product of cooperation between the first author (JDH), the supervisor/second author (MS), and the research assistant, the pronoun “we” is used throughout the paper to denote the researchers and the research assistant.

1.2 Migration worldwide

With rapidly increasing globalization and worldwide migration, providing culturally competent care is becoming an increasingly important priority [1]. As migrants cross distances and borders, they carry with them diverse epidemiological profiles, as well as cultural beliefs and practices that may diverge from those of their host countries [2]. While some migrate voluntarily, millions of people are internally displaced or have sought refuge in other countries as a result of war, famine, poverty, or environmental disasters.

Research on migrants' health reveals complex relationship and heterogeneous findings [3]. Reviews indicate that migrants experience reduced access to healthcare and substandard health outcomes when compared to natives in a number of industrialized countries [4]. Substantial reviews also demonstrate that refugees suffer from complex mental health challenges, as exemplified by the findings that refugees who have resettled in Western countries are ten times as likely to suffer from post-traumatic stress disorders than the population at large [5]. Despite the massive challenges increased migration poses, immigrant health status and needs are still poorly understood [6]. Thus, more research is needed to better understand and respond to the health needs of migrants, and in particular the needs of refugees and asylum seekers.

1.3 Migrants' experiences and perceptions of healthcare services

Given the substantial health needs of immigrants, it is especially important to understand how these populations perceive and experience healthcare services. We will look more closely at conceptual frameworks related to these terms later, but for now, let us review empirical data in this field, with a particular focus on qualitative studies.

1.3.1 Empirical data

Utilization of services: A systematic review of immigrants' vs. non-immigrants' utilization of healthcare services found that immigrants tended to utilize services less frequently than non-immigrants [7]. However, studies performed in the United States (U.S.) yielded significantly larger differences between immigrants and non-immigrants, than studies performed in Canada and Europe. As the U.S. healthcare system has a radically different structure from Norwegian healthcare and other European healthcare systems, it is therefore important to consider where studies are conducted in order to assess the potential transferability of the findings. Several studies have also explored potential differences in immigrants' and natives' use of emergency room (ER) services. A Danish study found that utilization rates of ER services were higher for some immigrant groups, while other immigrants groups visited the ER at similar rates as Danish-born residents [8].

Patient Satisfaction: One important element of patients' perceptions of healthcare services is patient satisfaction, which is often viewed as a key indicator of the quality of healthcare services [9]. Data suggests that in several European countries, including Norway, non-Western immigrants are less satisfied than the native population with general practitioner (GP) services [10-12]. Dissatisfaction among immigrant patients is often related to communication difficulties and lack of mutual understanding [11,12]. Research from the U.K. found that refugees and asylum seekers were generally satisfied with the provision of services, though some noted a lack of continuity of care [13,14].

Trust in GPs: An in-depth exploration of Afghani refugees' views of GPs in the Netherlands highlighted the importance of trust in the GP-patient relationship, while another interview study concluded that visiting different clinics contributed to a lack of trust among chronically ill immigrant patients [15,16]. A U.K. study cited that a lack of trust in GPs was influenced by views of GPs not being specialized and unqualified to respond to a range of illnesses, which led some immigrants to bypass GPs and seek ER or hospital-based care [13,14].

Past experiences: Other qualitative studies from migrant patients' perspectives have highlighted the role of past experience on current views of healthcare systems. Findings pointed to migrant patients having difficulties adjusting to the large differences between the structure of the healthcare system in the home country and the new country [17].

Access to care: Though few qualitative studies on barriers and enablers to access among migrant populations in Europe exist, some data suggests that barriers to care include language difficulties, cost of medication, and difficulties accessing secondary care [13,18]. Qualitative data also indicates that failed asylum seekers and refugees without social support from family or refugee agencies have greater difficulties accessing healthcare services than the refugees and asylum seekers at large [18].

Health Literacy: Another central component of immigrants' experiences with and perceptions of healthcare is "functional health literacy," defined as "the ability to read, understand, and act on health information" [19]. Immigrants are particularly vulnerable to limited health literacy, and the consequences of inadequate health literacy include poor

self-reported health and health outcomes, limited understanding of medical information, lack of utilization of preventive services, and poor adherence rates [19].

Use of interpreters: Language gaps and difficulties related to cross-cultural communication have often been cited as influential factors in migrants' encounters with healthcare systems [13,20]. A systematic review found that inadequate provision of interpreters is likely to compromise the quality of care for patient in need of interpreters and patients with mental disorders [21]. Qualitative studies from the U.K. and Sweden found that immigrants deemed it important to have an interpreter present; however, concerns existed regarding the roles and confidentiality of interpreters [13,20].

Stigma and discrimination: While stigma and racism have been explored among persons of different ethnicities (e.g. African American, Hispanic, and Caucasian) in Western countries, limited research has examined the potential influence of stigma or discrimination on migrants' healthcare encounters specifically [22-24]. Some qualitative studies have shed light on this topic; however, they have yielded differential findings regarding immigrant patients' perceptions of whether they are treated differently than non-immigrants. While participants in some studies reported stigma and perceived discrimination on the basis of their immigrant status, others explicitly stated that they did not believe their immigrant status or other migration-related factors influenced the quality of care they received [15,23,25]. Several articles urged for more knowledge on the role of stigma and discrimination in health-seeking behavior [14,18].

1.3.2 Assessment of the literature

The field of immigrant health is still underdeveloped, and the majority of the literature on migrants focuses on pathology. Moreover, existing literature related to migrants' experiences and perceptions of healthcare services is largely dominated by quantitative studies. Thus, the qualitative literature base in this field is still in its infancy. There are substantial methodological challenges to many of the studies, as convenience samples and small-scale studies are prevalent. Still, existing literature on immigrants' health experiences worldwide does provide valuable insight that can help contextualize the experiences and perceptions of Iraqi immigrants in relation to Norwegian healthcare. In the following

sections, we will discuss existing research regarding the Norwegian healthcare system's encounters with immigrants in general, and with Iraqis in particular.

1.4 Migrants and the Norwegian Healthcare system

Norway has undergone rapid changes in the past decades, as an influx of refugees and asylum seekers have contributed to a shift towards an increasingly heterogeneous population. Immigrants and children of immigrants currently make up 11.4% of the Norwegian population, as well as 27% of the population of Oslo [26]. The Norwegian government has committed itself to provide equitable healthcare services for all residents; however, the increasing diversity in Norway's population challenges policy makers and healthcare providers to make culturally sensitive adaptations to ensure equitable and culturally competent care [27].

1.4.1 The Norwegian "gatekeeping" system

The Norwegian healthcare system is modeled on the "gatekeeping" system, which strives to assure that the majority of the populations' health concerns are met by primary care services. The Registered General Practitioner Scheme (RGP Scheme) postulates that each resident should be assigned to a registered GP. Ideally, this scheme would ensure continuity of care, effective provision of services, and appropriate referral to secondary care when necessary. Universal healthcare is provided through the National Insurance Scheme (NIS), and though inpatient care is free, limited co-payments for outpatient care apply. Also, some forms of care are generally not covered by the NIS, including dental and physiotherapy care.

1.4.2 Norwegian physicians' encounters with immigrants

While efforts have been made to ensure culturally competent care [28], research indicates that Norwegian healthcare workers still feel like they do not have access to sufficient resources, assistance, or knowledge to adequately meet the complex health needs of migrants, and of refugees in particular [29-31]. Immigrants are often perceived as a "problematic" patient group, and in one study, 29% of GPs reported enjoying working with a refugee patient less than working with an "average" patient [29]. In addition to

administrative challenges and difficulties coordinating care, GPs have also voiced concern that the RGP Scheme may be poorly suited for refugees, who often experience difficulties navigating the healthcare system [30,31]. Some GPs have attributed migrants' over-use of ER services to lower symptomatic thresholds, as well as impatience towards waiting for GP appointments [30].

1.5 Iraqi migrants, refugees, and asylum seekers

Due to continued violence in Iraq, over 4 million Iraqis are believed to be displaced around the world, and in 2006, Iraqis made up the largest single group of asylum seekers arriving in industrialized countries [32]. In Norway, Iraqis make up the largest group of immigrants with refugee backgrounds, and comprise the fourth largest immigrant group in general, after Swedes, Poles, and Pakistanis [26]. Iraqis also made up the largest group of asylum seekers in Norway for several years, up until 2009, at which point measures were taken to reduce the number of asylum applicants from Iraq [33].

1.5.1 Health research: Iraqi immigrants worldwide

There is little health-related research specifically relating to Iraqi migrants. However, a few quantitative studies on Iraqi refugees have cited high levels of psychological morbidity, including post-traumatic stress disorder, anxiety, and depression [34,35]. A cluster of studies on Iraqi asylum seekers in the Netherlands highlighted the following results: duration of asylum procedure was a risk factor for psychopathology in asylum seekers; a long asylum procedure negatively impacted quality of life and the overall health; and that lack of work, family issues, and asylum procedures were the post-migration living problems with the highest odds ratios for psychopathology [36-38]. These researchers also found that a large proportion of asylum seekers with psychological disorders did not get adequate treatment, indicating a mismatch between the asylum seekers' health needs and the type of services utilized [39]. An Australian study on Iraqi, Afghan, and Iranian immigrants found that health-seeking behaviors were most strongly predicted by country of birth, indicating significant differences between Iraqis and other Middle-Eastern populations [40]. For example, having a GP that spoke one's native tongue and ease of making appointments

were factors that were more likely to motivate Iraqis than other groups to seek health services.

1.5.2 Health research: Iraqi immigrants in Norway

Research on Iraqi immigrants as a whole is scant; however, research from Statistics Norway (Statistisk sentralbyrå, SSB) does give some indication of the health and health experiences of the Iraqi population in Norway. One landmark study compared the health status of the 10 largest immigrant groups in Norway, defining health status a construct of self-evaluated health, somatic diseases, deterioration in everyday well-being due to illness, psychosomatic pains and mental health issues [41]. Out of the 10 immigrant groups, Iraqis scored the lowest on this health-index, and when separated by gender, Iraqi women had the lowest score of all the male and female immigrants. Thus, Iraqi immigrants, and particularly Iraqi women, are among those with the largest burden of illness in Norway, also when compared to the general population.

Moreover, Iraqis were among the groups with the most frequent use of GP and ER services, as well as the most frequent admission to hospitals. On average, Iraqi immigrants had 6.5 GP consultations in the last 12 months, and Iraqi women reported 10 GP consultations in the last 12 months. When examined by gender, Iraqi women were also among those with the most frequent visits to specialists. Additionally, persons from Iraq reported the greatest frequency of using herbal medicine or seeking “alternative healthcare.” Iraqis also had the greatest self-reported need for interpreter in healthcare consultation, and 34% of Iraqi women reported a need for interpreter. 80% of Iraqis were satisfied or very satisfied with Norwegian healthcare services, and 80% also reported receiving care equal to what Norwegians receive. This was roughly equivalent to the views of the immigrant population at large. As elderly people tend to have a higher burden of illness and lower satisfaction rates than younger populations, it is important to note that the age of the Iraqi immigrant population is dominated by young adults [26].

These findings should be interpreted in light of Iraqis’ demographic profile, which has been detailed in other SSB reports [26,42,43]. For example, over 75% of Iraqis have lived in Norway for less than 10 years, which may contribute to their poor living conditions, including poor socio-economic status, low rates of employment, and poor language skills.

Most Iraqis grew up in urban areas, and heterogeneity dominated Iraqis' educational background. Two thirds of Iraqi immigrant women did not have experience working outside the home prior to migration, and 50% of Iraqi women reported spending more than 20 hours a week doing housework. Comparatively, only 7% of the Norwegian population reported spending more than 20 hours a week on housework. Four out of ten said they planned to move back to Iraq some day, and Iraqis were among the immigrant groups who scored lowest on the sense of belonging to or cohesion with Norway. The vast majority of Iraqi immigrants have a refugee background.

1.5.3 Kurdish Iraqis

A great deal of research on migrant health tends to make sweeping generalizations, discussing "non-Western" immigrants as though they were one homogenous group. However, substantial evidence indicates that patients' experiences and perceptions of healthcare services differ between immigrants of various cultures and ethnicities [44,45]. Literature also indicates that differences may exist among ethnic groups within the same country [46]; however, some have found that different ethnic groups within countries often share more similarities than differences, in terms of health beliefs and behaviors [44].

In Iraq, though a myriad of ethnic and minority groups exist, the people can roughly be divided into Arabs in the South and Kurds in the North. Given differences between Iraqi Kurds and Arabs, in terms of language, culture, religion, history, socio-political context, it would be reasonable to expect that some differences may exist between these groups in terms of health beliefs and practices. Thus, we only recruited Kurdish Iraqis for this study. For the purposes of this thesis, however, we have decided to maintain a broader perspective, by referring to "Iraqis," which includes, but is not limited to Kurdish Iraqis².

² It should be noted here that, given the Kurdish people's experiences of oppression and struggle for independence, many Kurds born in Iraq do not identify themselves as Iraqis. Though we are sensitive to the politicized semantics of this region, we have chosen to generally refer to the study population as "Iraqis," which includes, but is not limited to Kurdish Iraqis.

1.6 Gap in the literature

As demonstrated above, immigrants in general, and Iraqis in particular, experience large burdens of both somatic and psychological illness. Data suggests that when compared to the population at large, immigrants are more vulnerable to limited health literacy, and experience more barriers to access to care. Healthcare providers also express insufficient competency in meeting the complex needs of migrants, and particularly refugees. Despite these challenges, little systematic knowledge has been gathered regarding how Iraqi immigrants experience and perceive healthcare systems, neither in Norway, nor globally. This study will therefore provide attempt to begin to fill this gap in the literature.

Chapter 2: Conceptual frameworks

In the following, we will take a closer look at the theoretical underpinnings of concepts related to our study, and how they might serve to further illuminate our topic of discussion.

2.1 Theoretical background

We begin by highlighting a crucial difference between the meaning of the terms “disease” and “illness.” While disease refers to abnormalities in the structure and functions of bodily organs, illness may be viewed as the subjective perception of ill-health and the meaning one gives to that experience [47]. Thus, it is important to gain knowledge of not only the biomedical perspectives, but also patients’ subjective experiences of health and ill health.

In this study, we align ourselves with Kleinman’s view of healthcare systems and health behaviors as socially constructed and dynamic concepts, influenced by interactions between patients and healthcare providers [44]. One of Kleinman’s central concepts is that of “explanatory models,” which refers to patients’ and providers’ often differing patterns of thought regarding the cause, symptoms, cure, and etiology of illness. Kleinman’s theoretical framework also includes the view that healthcare systems are made up of three partly overlapping sectors including the popular-, the professional-, and the folk sector. Explanatory models are not always distinctly different among patients and providers, and evidence suggests that some explanatory models held in the folk sector are reinforced by the professional sector [48].

For the purposes of this study, we also operate with an understanding of culture as socially constructed, made up of dynamic processes. Though health systems and behaviors, and particularly explanatory models, may vary between people of different cultures [44], we do not view culture as the sole determinant of health systems, behaviors, or outcomes. Rather, we acknowledge culture as *one* of the potentially powerful influences on health beliefs and behavior, in addition to a host of other factors, including socio-demographic factors (such as gender, age, socio-economic status, and religion) and structural factors (including the availability, accessibility, and user-friendliness of healthcare systems).

2.2 Patient perceptions of healthcare services

As evidenced by the empirical research cited earlier, a multitude of patients' perceptions, including satisfaction, expectations, and trust play important roles in health outcomes. Here we will discuss these perceptions in further depth.

2.2.1 Patient satisfaction

User-oriented research on patient satisfaction with healthcare services has become increasingly popular, and patient satisfaction is often seen as a key indicator of the quality of healthcare services [9]. Several theories regarding patient satisfaction exist, most of which can be defined within the following three categories: actor-oriented theories (views satisfaction primarily as a result of qualities of the patients, including socio-demographic variables, expectations towards healthcare, perceived effect of treatment, etc.); relational theories (emphasizes the interaction between patient and provider as a source of satisfaction or dissatisfaction); and structure-oriented theories (point to characteristics of the healthcare system, such as the availability, accessibility, user-friendliness, effectiveness, and organization of the healthcare services) [9]. The different theories all add important perspectives, and research indicates that they work together in interplay, contributing to the dynamic nature of health-seeking behavior and experiences [49].

Patient satisfaction is a multifaceted and complex phenomenon, and empirical evidence is marked by heterogeneous findings. In fact, it has been suggested that *quantitative* research measuring patients' *evaluations* of care, tends to yield more positive findings than *qualitative* research assessing patients' *experiences* with healthcare [9]. Thus, when researching patient satisfaction, differentiating between patients' evaluations of and experiences with the healthcare system is essential, as negative experiences do not necessarily lead to poor evaluations, nor vice versa. Thus, we have taken care not to make assumptions, but rather to clearly differentiate between participants' experiences and evaluations, in the design, data-collection, and analysis phase of our project.

2.2.2 Expectations

The role of expectations and their potential impact on satisfaction and other health outcomes is contested by different researchers. While some evidence also suggests that

patients' expectations may be a possible predictor of patient satisfaction [50], others have critiqued this hypothesis [51]. Still, patient expectations are believed to be of central importance, and one study found that patient expectations are more malleable and complex constructs than previously believed, indicating that knowledge of this construct is still limited [52].

2.2.3 Trust

Finally, patient trust is another important component of patient perceptions. Trust is a multidimensional and complex construct, partly due to the lack of a standardized definition within and across academic disciplines. Though many theories exist, some of the most broadly recognized components of physician behavior in which patients place their trust are competence, compassion, privacy, confidentiality, reliability, and communication [53].

2.3 Access to healthcare

Access is another concept central to patients' perceptions and experiences of healthcare. Differing conceptualizations, taxonomies, and definitions of access exist and have been developed over time. In earlier research, it has been assumed that if healthcare services existed, patient access to healthcare services would be achieved. More contemporary researchers, however, emphasize that the mere existence of healthcare services is not enough to ensure actual, realized utilization and access to services [54]. Gulliford et al. have classified barriers to access to healthcare into three categories, which we will discuss in the following [54].

2.3.1 Personal

Personal barriers primarily consist of social and cultural factors. Examples of personal factors include patients' past experiences with healthcare systems and patients' perceptions of their own health needs, in conjunction with attitudes, expectations, and views of healthcare personnel and healthcare systems [54]. Explanatory models may also serve as barriers to care, particularly when explanatory models between patients and providers differ drastically [44]. Additionally, stigma, defined as a deeply discrediting attribute that reduces a person "from a whole and usual person to a tainted, discounted

one,” (p.3) may serve as a barrier to care [55]. Vulnerable populations are particularly prone to suffer from stigmatization, and stigma has been shown to have a strong and enduring effect of the well-being of some vulnerable populations [56].

2.3.2 Financial

Financial barriers relate primarily to the cost of services. It should be noted that even in societies that provide essentially free and universal access to services, as in Scandinavia, financial barriers may still play a role. For example, the deductible cost of transportation, GP appointments, equipment, and the cost of over-the-counter medicine, may serve as barriers to access of healthcare, especially among persons of low socio-economic status. Additionally, several “hidden costs” exist, including loss of productive work time.

2.3.3 Organizational

Organizational barriers to healthcare refer to attributes of healthcare systems, such as degree of availability, waiting times, and differing referral practices which may act as barriers to access to healthcare [54]. The degree of user-friendliness, including provision of interpreters and healthcare staff attitudes are also examples of organizational factors that can impact access to healthcare services.

This description of access is by no means an exhaustive list of all the potential factors that impact access, but rather an indication of some of the variables one must keep in mind when studying a population’s access to healthcare services.

Chapter 3: Research Questions and Rationale

3.1 Research Questions

On the basis of an extensive interdisciplinary literature review, we identified a near absence of research regarding Iraqi immigrants' health experiences. Thus, we formulated a broad main research objective, namely to explore Iraqi immigrants' perceptions and experiences with healthcare services in Norway.

Though we wanted to pursue emerging themes throughout the research process, we identified some sub-research questions as a starting point. These questions were developed on the basis of existing research and, to some degree, initial key informant interviews regarding what key members of Iraqi communities identified as research priorities (See section 4.5.1 and 4.6.3 for more information on key informants). The sub-research questions were as follows:

1. What makes up Iraqi immigrants' frames of reference, i.e. what are their experiences with the healthcare system in Iraq?
2. Where, when, and how do participants seek healthcare in Norway, and what are their experiences and perceptions of the Norwegian healthcare system?
3. What are Iraqi immigrants' conceptions of illness and health, and what influences participants' decisions whether to seek healthcare or not?

3.2 Rationale for the research

We have demonstrated a chasm in the literature, indicating a lack of knowledge regarding Iraqi immigrants' perceptions and experiences with healthcare in Norway. Research on this topic is needed, for reasons I will outline in the following.

Research has also demonstrated that Iraqi immigrants, both in Norway and elsewhere, experience a large burden of illness, including a high prevalence of psychopathology [35,57]. However, data on disease prevalence is not sufficient to address the health needs

of a given population. In order to provide equitable and culturally competent care for Iraqi immigrants in Norway, increased knowledge of Iraqis' perceptions and experiences with healthcare in Norway is needed.

According to the review of scientific literature related to immigrants and refugees in Norway from 1990-2009, the majority of the existing research tends to concentrate on conditions in Norway, rather than seeing migration-related issues in light of the conditions in the home countries [58]. This study will therefore contribute to the understanding of how participants' frames of references from their home country may contribute to their expectations and experiences in Norway.

Existing literature demonstrates indicates that Iraqi migrants in Norway are among those with the most frequent use of GP, ER, and specialist services, while research from other settings indicates a mismatch between the health needs and the types of health services utilized [39,57]. However, little is known about the mechanisms behind these findings, thus, qualitative research is needed to gain deeper understanding of Iraqi immigrant patients' perceptions and experiences in relation to their access to and utilization of services.

Lastly, as over 4 million Iraqis are displaced worldwide [32], the magnitude of the Iraqi Diaspora is another compelling argument for why the Iraqi population should be studied.

Chapter 4: Methodological Design

The purpose of this chapter is to demonstrate our methodological choices and challenges throughout the research process, by explaining the rationale behind our methodological choices and by giving concrete examples of how we carried out the study.

4.1. Study design

We chose an explorative and primarily inductive research design, to gain in-depth understanding of the most salient aspects of Iraqi immigrants' health-related experiences, as defined primarily by the members of the study population themselves.

4.2 Study population, inclusion and exclusion criteria

In order to allow for comparisons with other research projects from Norway, we chose to adhere to Statistics Norway's (SSB) definitions, outlined in Operational Definitions. We defined the study population as Iraqi immigrants over the age of 18 living in Norway. As explained previously, we restricted the study population to ethnically Kurdish Iraqis (See 1.5.3).

Additionally, we specified that the participants had to be covered by the Norwegian Insurance Scheme (NIS), due to the ethical requirement that all participants should have access to healthcare services in case they would require psychological or somatic care as a result of participating in the interviews. As undocumented migrants are granted partial or no NIS coverage, requiring membership in the NIS would effectively eliminate undocumented migrants from the research. We conducted a key-informant interview with the leader of a group of undocumented Iraqi immigrants to assess whether or not this group ought to be included in the study population. Given the complex health care needs and experiences of undocumented immigrants, we found that this group fell outside the scope of our study.

Thus, inclusion criteria for participants in the research were as follows:

- Persons over the age of 18
- Persons born in Iraq
- Persons born abroad by two foreign-born parents and have moved to Norway
- Persons who identify themselves as Kurdish and speak Kurdish
- Persons who are completely covered by the National Insurance Scheme

Conversely, the exclusion criteria for participation were as follows:

- Persons *under* the age of 18
- Persons *not* born in Iraq
- Persons *not* born abroad by two foreign-born parents nor have moved to Norway
- Persons who *don't* identify themselves as Kurdish nor speak Kurdish
- Persons who are *not* completely covered by the National Insurance Scheme

It is important to note that though the participants were informed that they had to fulfill the inclusion criteria in order to participate, participants were never asked to provide any documentation to prove that they fulfilled these criteria.

4.3 Study setting and approaching the field

The study was conducted in the greater Oslo area in Norway, which includes the diverse and urban counties of Oslo and Akershus. In Oslo, immigrants and Norwegian-born to immigrant parents make up 27% of the population, and 7% of the population have a refugee background [59]. Akershus is the second most diverse county in Norway in terms of absolute numbers, as over 70 000 immigrants and Norwegian-born to immigrant parents live here [59].

In preparation for the field research, we felt it was important to obtain a deeper understanding of the study setting and context; thus, we took an ethnographic approach to the field. A broad range of themes, including history, language, religion, and culture were explored in an Iraqi context through attending conferences and meetings, reading books, watching films, and, perhaps most importantly, through interactions with members of Iraqi communities. Through informal key informant interviews at an early stage of the research process, we also sought to learn more about what members and leaders of Iraqi

communities themselves saw as the most salient issues to explore in the research (See 4.5.1 and 4.6.3 for more information on key informants).

4.4 Finding and working with the research assistant

As approximately 75% of Iraqi immigrants have lived in Norway for less than five years, and tend to rate themselves as having poor language abilities, we deemed it essential to provide participants the option of utilizing an interpreter during the interviews [43]. In order to reduce the number of persons involved with the data, we decided to hire a bilingual research assistant that could act as an interpreter in all of the interviews. That is, we wanted someone who spoke Norwegian or English and at least one of the major Kurdish Iraqi dialects: Sorani, Badini, and Kurmanji.

We deemed motivation, a flexible schedule, and ability to translate the meaning of the interviews as the most important qualities for the job. Thus, we decided to primarily recruit students from the University of Oslo (UiO) and the University College of Oslo (HiO). We distributed recruitment posters (in Norwegian and Iraqi languages) at career centers, to coordinators of particularly salient study fields (including the fields of interpretation, anthropology, and Middle-East studies, and medical sciences), and to Iraqi student organizations.

12 qualified applicants applied for the job. After interviews and a discernment process, we decided to hire a Kurdish woman from Iran. She had lived in Iraq for several years, spoke fluent Sorani (the main Kurdish Iraqi accent), and was able to communicate in Badini and Arabic as well. Moreover, she had lived in Norway for several years and spoke fluent Norwegian, which equipped her with a thorough understanding of Norwegian language and culture. Though both men and women were welcome to apply for the job, we were happy to find an excellently qualified woman, as some female participants most likely would open up more in the presence of a woman than a man. Similarly, though we did not require formal interpreter experience, the research assistant did have several years of experience as an interpreter and was almost finished with her education to become an accredited interpreter. This proved to be an extremely valuable asset to the research process, as she

had several years of insight from working as an interpreter in GP sessions, at psychologists, in hospitals, at crisis centers, and in other welfare and health related settings. She had also worked at crisis centers for abused women for several years.

It was important for us to integrate the interpreter into the research team, thus, we primarily referred to the interpreter as “the research assistant.”³ Before beginning data collection, we engaged in a training period, during which the research assistant familiarized herself with the project and the methods we used. Long discussions and mutual learning characterized these weeks, as the first author learned a great deal from the research assistant’s experiences and points of view. The research assistant and the first author continued to work closely together throughout the research process, and spent long hours discussing, coding, and analyzing the interviews upon completion. Periodic evaluation meetings, which permitted both the first author and the research assistant to raise any concerns about the working environment contributed to a positive and friendly working relationship, which was instrumental to the quality of the work.

4.5 Sampling and recruitment

4.5.1 Key informants

We also recruited 15 persons for informal key informant interviews. The key informants were approached individually, upon being identified as persons who had extensive experience with Iraqi immigrants in Norway. They were identified as such persons, either by virtue of their professional work, or by virtue of their role in Iraqi communities as leaders or experts. The key informants were recruited from a large variety of fields, and ranged from community leaders, to healthcare personnel, to asylum reception center staff, to UDI officials, and more (see Table 1). The research assistant who drew upon her many years of working as an interpreter, as well as her intimate knowledge of Iraqi society to help conduct and analyze the interviews, also served as a key informant. In fact, she played an instrumental role in the contextualization and in-depth understanding of the participants’ and key informants’ accounts.

³ Consequently, we will refer to “the interpreter” and “the research assistant” interchangeably throughout this monograph.

4.5.2 Participants recruited for in-depth interviews

We conducted a purposive sampling, with the goal of maximum variation [60]. Specifically, we sought to attain maximum variation in the following participant attributes: gender, age, years spent in Norway, highest completed education, and immigration status (i.e. asylum seeker, refugee, family reunification). We recruited 10 participants, 5 female and 5 male, who took part in two in-depth interviews each, for a total of 20 in-depth individual interviews. A group interview with 4 female participants was also conducted.

Given the fact that the Kurdish Iraqi communities in the greater Oslo area are relatively small, concerns about the confidentiality of the participants do not permit us to list the specific demographics of each participant, thus, we point to a table with characteristics of the participants as a whole (Table 2). The categories of age, years spent in Norway and highest completed education were relatively equally spread in the male and female groups. There were no males on family reunification visas and no female asylum seekers at the time of the interviews; however, this gender imbalance in immigration status is typical among several immigrant-groups in Norway [61].

Asylum reception centers, non-governmental organizations, and Iraqi community organizations and businesses were contacted regarding recruitment for the study. With the consent of a contact person at each recruitment site, we distributed information posters at the recruitment sites. We also asked some recruitment sites to circulate the information poster to those in their networks that were eligible for participation.

The information poster included information about the research project, the purpose of the research and the voluntary nature of the project. Persons interested in participating were asked to fill out their contact information as well as list some demographics (gender, age, years lived in Norway, and highest education attained), and return this to the first author. Though residency status was also a demographic in which we sought maximum variation, we did not ask potential participants for this information at this time, as key informants instructed us that this could provoke suspicion about governmental ties. The information poster was translated from Norwegian into the main three Kurdish Iraqi languages. A tri-lingual Kurdish-speaker confirmed that they were translated correctly.

A contact person at each recruitment site would typically relay the contact information of those interested in participating to the first author, leaving it to us to contact the participants. A few participants were also recruited through snowball sampling or through direct encounters with the first author at Kurdish Iraqi organizations' gatherings. However, each participant was still carefully chosen on the basis of obtaining a maximum variation sample.

Once in contact with potential participants, we would provide additional information about the research, ask if the participants had any questions or concerns, and, lastly, ask if they were interested in setting up a time for an interview or a focus group discussion. Four persons declined participation, predominantly due to lack of spare time. The interviews took place at the location of the participants' choice, such as participants' homes or a reserved room at the University of Oslo campus.

4.6 Data collection tools

In-depth interviews were chosen as the primary data collection method, in addition to a group interview and 15 informal key informant interviews. In the following, we will describe the utilization of these methods in more detail.

4.6.1 Individual In-depth interviews

Considering the nature of the research question, we found in-depth interviews to be the most suitable method for data collection. This method was chosen over other qualitative methods like participant observation and textual analysis because we aimed to capture in-depth accounts of the participants' experiences, views, beliefs, and attitudes towards the primary healthcare system in Norway.

Thematic interview guide: A thematic interview guide was employed in the interviews. There were several concerns that prompted us to choose this over a semi-structured interview guide. Firstly, not being bound to a structured interview guide would allow us to form categories based on the stories of the participants, rather than imposing preconceived categories onto the participants' experiences. Moreover, given the lack of research in this

area, we wanted the participants to be able to speak freely, allowing us to pursue emerging themes in subsequent interviews. However, as a starting point, we chose three main themes, reflecting the research questions.

1. Experiences with the healthcare system in Iraq in general
2. Experiences with and attitudes towards primary health care in Norway
3. Perceptions of illness and health

Given the first author's inexperience in conducting qualitative interviews, we knew it would be useful to write out examples of questions and probes for each major theme. Thus, we drafted a range of probing questions, utilizing Patton's typologies of questions (experience/behavior, opinions and values, feelings, sensory, background/demographic, time frame) to ensure a broad variety of questions [60].

A pre-testing interview of the thematic interview guide revealed that it had been too theoretically oriented and were not easily understandable or meaningful to the participant. This led to a revision of the interview guide and the sample questions, though the main themes remained the same. As the first author became more comfortable and confident in the researcher role, the first author relied less on the written questions and focused more on picking up on themes and signals raised by the participants. Throughout the rest of the research process, the interview guide was continually revised and developed, and themes were added and subtracted according to the emerging issues raised by the participants.

Two interviews with each participant: We decided to conduct two interviews with each in-depth interview participant. This decision was based on several factors. First of all, among the scant existing research in this field, a key article cites the importance of establishing trust when engaging in a relationship with asylum seekers and refugees [13]. This notion was also emphasized by a psychologist key informant, who had extensive experience working with refugees. He noted the importance of value of repeated interviews as a basis for establishing rapport and obtaining high-quality data. Further, we also considered the fact that most immigrants have gone through government interviews to determine their future in Norway. Thus, getting to know the participants through repeated interviews laid the foundation for trust, and provided the opportunity for explaining the purpose of the

research, as well as the researchers' independence from the Norwegian government, thoroughly and repeatedly.

Another function of the repeated interviews was member checking. In other words, we would use the second interview as an opportunity to present our initial understanding and interpretations of the participants' statements and opinions from the first interview. The participant would then be encouraged to reject, accept, nuance, expand, or otherwise comment on the researcher's understandings and interpretations. Given the gap in language and culture between the researcher and participant, the second interview also provided the opportunity to clarify potential misunderstandings based on language and meaning.

Use of interpreter: All the participants were asked if they preferred to conduct the interview with or without an interpreter present. In some instances, participants did not request an interpreter, however, the language gap made it difficult for the first author to fully understand the participants. In such cases, we would approach the participants and gently ask if they would mind having a translator present in order to help ensure that the researcher would not misunderstand or misinterpret their stories. Then we would reiterate the fact that the participants were still free to say no, and that the interviewers would like to interview the participant regardless of whether or not a translator was present. This request was met with understanding, and all who were asked, welcomed the presence of the interpreter.

Language during the interviews: The participants were offered to conduct the interview in Norwegian, English, or one of the major Kurdish Iraqi dialects, Sorani, Badini, or Kurmanji. The research assistant's mother tongue was Sorani, however she could also speak Badini almost fluently, and also had basic understanding of Arabic and Kurmanji. Most of the interviews were conducted in Sorani, while one participant, a Badini native, spoke in a mix of Kurdish dialects and Arabic. Both the participant and the research assistant expressed that they were able to understand each other well, as they were both accustomed to communicating in various languages at one time.

Conducting the interviews: The first author conducted all of the interviews. Additionally, the research assistant was present as an interpreter in half of the interviews. The interviews were conducted at the location of the participants' choice, which ranged from the participants' homes and workspaces to a reserved room at the University of Oslo campus, to a café. We typically spent between 15-45 minutes getting to know the participants, building rapport, and establishing a relaxed and comfortable atmosphere before formally beginning the interview. We would then present the informed consent form, discuss the participants' potential questions and concerns, and ask the participant to sign the consent form before commencing the interview. Though the length of the interview varied from 75 minutes to 180 minutes, each interview averaged around 2 hours. All of the in-depth interviews were recorded with the participants' consent, using a digital dictaphone. Observations about the participants' body language and other non-verbal cues were also written down.

Reflexivity and participant welfare: Reflexivity and awareness of one's own body language, facial expressions, and tone of voice was something that was stressed in preparation for each interview. Moreover, the research assistant and principal investigator had spent a substantial amount of time together and were comfortable with each other, which we sensed set the stage for a comfortable environment. Our observations of the research participants' nonverbal behavior indicated that they generally felt at ease and comfortable during the interviews, though some exhibited strong emotions, such as crying or raising their voice, while speaking about negative events. Each interview ended with a short debriefing session, in which we would usually ask the participants how they felt in that moment. Most participants reported a sense of relief and that it felt good to tell their stories and to have someone listen. There were, however, some exceptions, most notably a woman who had shared that she was in an abusive relationship. She expressed strong emotions of distress and fearfulness. Seeing her reactions, we stayed with her, and did our best to calm and reassure her (without making promises we weren't sure we couldn't keep), until she was visibly calmer and reported feeling better.

Post-interview reflection: Every interview, regardless of whether it was conducted by the first author alone, or together with the research assistant, was followed by a post-interview reflection. This reflection typically took place shortly after the completion of the interview,

and provided an opportunity for the first author and, when applicable, the research assistant, to examine the interview in a reflexive way. We would begin by expressing our initial impressions from the interview, such as statements or non-verbal signals that were particularly interesting, perceived contradictions, etc. This was also a time for asking clarifying questions related to the meaning of words or concepts that they participants had mentioned during the interviews. We would then move towards a reflexive evaluation of the interview itself, examining which and how questions were asked; which questions were *not* asked; the physical space of the interview, including how we sat and moved in the room; and suggestions for improvements. We would also make sure to systematically recap the main themes of the interviews and consider adding or subtracting themes from the thematic interview guide. These reflections would be written down in a field note, which would accompany the transcript of the interview (See chapter 4.7 for more information on data handling and analysis).

It should be mentioned here that given the large amount of concentration needed to perform the interview well, the quality and depth of the post-interview reflection often depended upon the physical and emotional energy we had left right after the interview. In general, however, we strove to perform this process as thoroughly as possible upon the completion of each interview.

4.6.2 In-depth group interviews

We had initially decided to conduct four focus group discussions, two with health care workers and two with Iraqis, to compliment and triangulate the findings from the in-depth interviews. As focus group discussions are well-suited for eliciting a range of opinions and negotiating different views, this would have been an appropriate method for triangulating the findings from the individual in-depth interviews. Given the sensitive nature of the topics and the relatively small sizes of the Kurdish Iraqi communities in Oslo, we wanted to recruit new participants for the focus group discussions, rather than to ask those who had participated in interviews to also take part in focus group discussions. This recruitment process proved to be extremely challenging, thus, given our constraints in time and resources, we decided to refrain from using focus group discussions as an additional method.

Still, throughout the data collection phase, we registered the need for further exploration and clarification of some of the issues raised in the interviews with women. Thus, we conducted a small in-depth group interview with an additional four female participants. The group interview very much resembled the individual interviews; however, there were some notable differences, which we shall discuss in the following.

The primary goal of the group interview was to further explore, nuance, challenge, and validate or reject some of the notions that had been raised in previous interviews. The secondary goal of the group interview was to obtain new information from a plenary session. The group interview was conducted in the home of the research assistant, according to the wishes of the participants. Some time for refreshments and icebreakers was set aside before the interview began. In order not to interrupt the flow of the conversation in Kurdish, the research assistant had been trained to conduct the interview. Thus, the research assistant facilitated the group interview, gathering the participants in a circle. In further efforts not to disrupt the conversation, the first author sat outside of the circle, taking notes while an external interpreter simultaneously translated the conversation. The group interview lasted approximately two hours, with a small break after the first hour. During this break, the first author conducted a short debriefing session with the research assistant, discussing the themes that had been brought up, which themes ought to be explored further in the second half, and practicalities relating to the conduction of the interview. The group interview was recorded with the participants' consent, using a digital dictaphone. Upon the completion of the interview, we engaged in a thorough post-interview reflection (See section 4.7 for more information on how the data was managed and analyzed).

4.6.3 Informal key informant interviews

The first author carried out 15 informal key informant interviews and conversations. Most of the key informant interviews were conducted either towards the beginning or the end of the research process. In the early stages of the research process, key informant interviews were conducted to learn what leaders and members of Kurdish Iraqi communities saw as meaningful themes to explore in the research; to solicit concrete advice about how to carry out research in Kurdish Iraqi communities in a respectful and meaningful way; as well as to gain a deeper understanding of Kurdish Iraqi history, languages, religions, and cultures. Key

informant interviews carried out later on in the research process aimed to obtain a broad range of perspectives that would contribute to contextualize, nuance, challenge, and/or validate the findings from the in-depth interviews.

Given this range of objectives and the informal nature of many of the conversations, no interview guide was created. Rather, conversations developed from the key informants' expertise and the needs of the project, and we aimed to keep an open mind, encouraging key informants to speak freely. The first author took extensive notes during the interview, and completed post-interview reflections. During the post-interview reflections, the aim was to expand on the notes from the interview, noting initial impressions, questions, and the main themes of the conversations, while keeping a reflexive mindset in efforts to reduce bias. The main themes from these informal key informant interviews were also discussed with the second author and the research assistant.

4.7 Data management and analysis

All of the interviews were taped and transcribed verbatim, by the first author and the research assistant. The interview data was analyzed using the Systematic Text Condensation method, inspired by Giorgi's [62] phenomenological analysis, and modified by Malterud [63]. The qualitative analysis program, NVivo (9th edition) was utilized to create codes based on the results and to organize the data. In the following, we will describe the management and analysis of the data in greater detail.

4.7.1 Transcription

All in-depth interviews were transcribed, typically within a few days of conducting the interview. The first author transcribed the 10 in-depth interviews that were conducted without the research assistant present, while the research assistant transcribed and translated the remaining 10 in-depth interviews as well as the group interview. In terms of the level of detail of the transcriptions, we chose to denote laughter, pauses, crying, accentuated words or phrases, as well as any other gestures or non-verbal behavior that we had recorded in our notes from the interviews. We strove to transcribe in verbatim mode, but this was often complicated by the fact that half of the participants expressed

themselves in their second language. Consequently, we would usually rephrase the sentence in our own words in parenthesis after the original sentence, rather than rewording the sentence, in order to prevent us from imposing our own interpretations onto the transcripts. In some instances, however, statement makes sense when expressed orally, but, when transcribed verbatim, can be confusing and obscure the original intent of the statement [63]. Thus, in a few cases, slightly modified verbatim mode was used to preserve the original meaning of a statement.

4.7.2 Translation

The process of transcription was complicated by the fact that half of the interviews were conducted in Kurdish. Though we considered having the research assistant first transcribe the interviews in Kurdish and then translate them to Norwegian, this would be such a resource- and time-consuming process, that it would detract from other aspects of the work. Thus, the research assistant translated and transcribed the interviews simultaneously. We did our best to enhance the validity of this process, though, by discussing each interview thoroughly in the post-interview reflection before the onset of transcription. Once the transcript was completed, we would typically import the transcript into the NVivo program, and go through the interview, sentence by sentence, while also listening to the audio recording. We would then have thorough discussions regarding the meaning of the statements and storied, both on a linguistic level (discussing the meaning of particular words and expressions in Kurdish and Arabic), as well as on an analytic level (discussing different possible interpretations).

Additionally, an independent interpreter translated two randomly chosen interviews. Upon comparison, we found that the content and meaning of the interview was the same in each interview, with only minor differences in terms of phrasing. This process therefore enhanced the validity of the translation carried out by the interpreter.

4.7.3 Systematic text condensation

The data was analyzed using the Systematic Text Condensation method, inspired by Giorgi's [62] phenomenological analysis, and modified by Malterud [63]. This method was chosen over other analytic tools, such as discourse-, narrative- or semiotic analysis, because it is well suited for transverse analysis that synthesizes and systematizes information from a

range of participants. This method is not solely driven by theory, nor by immersion in the data. Rather it takes the middle road, by which the researchers identify units of meaning within the text and develop categories based on these, thereby condensing and reorganizing the data in a systematic manner [63].

The process of Systematic Text Condensation follow the following four stages: (i) reading the material with an open mind, noting main themes; (ii) identifying units of meaning regarding Iraqi immigrants' perceptions and experiences; (iii) grouping the units of meaning into codes and summarizing the contents of each code; (iv) writing synthesized descriptions, based on the units of meaning, of Iraqi immigrants' experiences and perceptions.

Practically speaking, this process would typically be carried out by conducting post-interview reflections; listening through the interview at least once with as open of a mindset as possible and then noting the main themes; listening through the interview once more during transcription; identifying units of meaning through coding the transcript in NVivo; revising the codes and creating sub-codes in NVivo; abstracting and condensing the units of meaning into a short text and finding salient quotes to reflect this meaning; and creating descriptions that summarize and generalize the main points from within each code. This process was carried out together with the research assistant for all the interviews in which the research assistant was present.

Chapter 5: Reflexivity and Validity

Qualitative methods are increasingly recognized and practiced in medical research; however, many still criticize qualitative research for being subjective and for not being valid. Thus, we will briefly review the criteria for validity in social research, as defined by Kvale and Brinkmann [64]. According to these authors, validity can be socially constructed, and may be defined as “freedom from bias, as reflexivity about presuppositions, as inter-subjective consensus, as adequacy to the object, and as the object’s ability to object,” (p.242) which we will discuss in the following.

5.1 Reflexivity and reduction of bias

Reflexivity, namely the ability to think critically and reflectively about one’s own presuppositions, roles, biases, and other influences on the research process was another essential element to “constructing the validity” of our research [64]. One concrete example of the reflexivity sought in this project, is the first author’s field journal. The first field journal entries are dated back to December 2008, and chronicle the development of research ideas that ultimately developed into this research project. By reading the field journal, we can observe many of the epistemological, methodological, practical, and personal choices and reflections that have shaped the project along the way. Furthermore, frequently revisiting past journal entries aided in uncovering biases and unconscious processes, which in turn have helped us counteract their influences as quickly and effectively as possible. For example, after having conducted a few interviews, we returned to the field journal to re-examine the development of the interview guide. In doing so, we uncovered, for example, that a subconscious inclination towards emphasizing patient-doctor communication over other aspects of the respondents’ encounters with the healthcare system had influenced the development of the interview-guide. This discovery allowed us to adjust our course, revise the interview guide, and remind ourselves to remain open to a broad range of topics related to the participants’ healthcare encounters.

Another important aspect of reflexivity is acknowledging the inherent subjectivities in research. No one enters a field of study without preexisting beliefs, judgments, or ideas.

Thus, rather than denying biases, we have aimed to acknowledge *how* our backgrounds, interests, and lenses have impacted the research process, from conception to completion. While both authors share an academic background in international public health, JDH is trained in social sciences and psychology, while MS' academic background is in anthropology and nursing. We are both ethnically Norwegian, and have spent a significant amount of time living abroad and studying multicultural issues. These are but some of the factors that have shaped our lenses and worldviews.

The research assistant, a Kurdish woman who is originally from Iran, fled to Iraq at a young age and lived there for several years. She could therefore relate to the participants in their native tongue and understand their context, while, as an Iranian, still exhibit a somewhat more removed and objective role than if she were Iraqi. She had extensive experience from interpreter work in Kurdish communities in Norway, as well as considerable experience working with abused immigrant women.

Recall bias and social desirability response bias were also potential limitations of the study. Efforts to counteract these biases included deliberately inviting in-depth accounts of past experiences, rather than asking direct question or soliciting broad, generalized statements. Additionally, conducting repeated interviews also aided in developing rapport, permitted in-depth knowledge of respondents' experiences and perceptions, and enabled us to challenge seemingly contradictory statements.

Negative case analyses were also employed to reduce bias. For example, as we began to see how expectations were influential in participants' satisfaction with healthcare services, we tried to resist the urge to prematurely accept this hypothesis, in part by seeking out data that might disprove our nuance our view of expectations as influential in participants' satisfaction with health care.

5.2 Validity and the use of an interpreter

The use of interpreters in cross-cultural and cross-language studies is a contested issue [65]. Some question the validity of interpreter-mediated research, arguing that interpreters' backgrounds influence the interview atmosphere, and, consequently, the

validity of the data [66]. We did our best to reduce the potential bias of using an interpreter through a number of measures described in the methods section, including reflexive dialogue, negotiation of meaning, and independent translation of two interviews.

Moreover, some authors recognize the positive impact interpreters can play in cross-language and cultural research, especially when interpreters are integrated into the research team and process and become objects of reflexive scrutiny [67]. Indeed, some researchers urge that interpreters take on the role of “cultural brokers,” aiding researchers in contextualizing the findings and comprehending unstated or subtle cultural meanings in the verbatim accounts [65]. Our intentional integration of the interpreter as a cultural broker in the analysis and contextualization of the findings can therefore be viewed as a strength.

While some authors contend that respondents are more likely to share experiences when interviewed by trusted members of the community being studied [68], others argue that using interpreters too closely aligned with the study population can lead to bias, as they might interpret selectively in order to “protect” the population [69]. Our interpreter, being an Iranian native, but having spent many years in Iraq, was both an outsider and a trusted community member. This dual role permitted a flexible position, allowing both access to and appropriate distance from the Iraqi participants.

5.3 Intersubjective consensus

“Intersubjective consensus” refers to the degree of concurrence between two (or more) parties’ coding of an interview. This may be measured mathematically, but it can also be understood in terms of “dialogical intersubjectivity.” Such dialogical intersubjectivity can be attained through mutually critical discussion between researchers in analysis, as well as between participant and researchers through the negotiation of meaning during the interviews. In our research project, the research assistant was an active and critical discussion partner throughout the analysis period, thereby promoting dialogical intersubjectivity during analysis. Such analytic intersubjectivity was also sought through frequent meetings, phone-calls, and correspondence between the first and second author,

in which emerging themes and the meaning of interviews were critically analyzed, and negative case analyses were performed. We also aspired to attain dialogical intersubjectivity with the participants during the interviews, through conscious interviewing techniques, such as rephrasing the participants' statements or by presenting our interpretations of the participants' stories, thereby engaging in a discussion about the meaning of their stories and statements.

5.4 The ability to object to researcher interpretations

Creating an environment in which the participants are fully able to object to the researcher's assumptions and interpretations is another element of objectivity. Unlike structured surveys, qualitative interviews allow for negotiation, objection, clarification, and disagreement on the part of the participant. In fact, this is something that we specifically encouraged in a number of ways. First of all, we would usually start each interview by reminding the participants that we were interested in obtaining a range of views, thereby promoting an environment in which the participants could speak freely. Secondly, we would often specifically articulate that we intended to present our interpretations of their stories, and that the participants were invited to object, clarify, or disagree to these interpretations. The interview transcripts indicate that the participants would frequently correct the researcher's interpretations of their statements, though some participants rejected, clarified, and negotiated the meaning less than others. Though we did our best to create an open and flexible environment, it is possible that some participants, and in particular some of the women or the illiterate participants, may not have felt completely free to object to the researcher's interpretations.

Chapter 6: Ethical considerations

Ethical clearance was obtained from the Regional Committee for Medical Research Ethics in Norway; however, as reflected in this chapter, we sought to be continually aware of the ethical implications of our work throughout the entire research process, as we viewed consent as an ongoing process [70]. As we encountered unanticipated ethical challenges, we remained committed to preserve the welfare of the participants and sought to engage in critical conversations between the first and second author, as well as an open dialogue with the Regional Committee for Medical Research Ethics in Norway.

6.1 Informed consent

All of the individual and group interview participants were asked to give their informed consent to participate in the interviews. The informed consent forms (see appendix I and II) were approved by the Regional Committee for Medical Research Ethics; however, this did not absolve us of the responsibility to ensure that all participants were thoroughly informed of what they were participating in. One of the challenges in ensuring informed consent among a group of people from a collectivistic, rather than individualistic, culture lies in the fact that many Iraqis may not have been exposed to the idea of interviews as a basis for exploring and defining the self and one's unique perspectives. Additionally, for many Kurdish Iraqis, interviews conducted with government officials in order to obtain a visa to live in Norway may have been their only previous experiences with interviews. Thus, we discussed the purpose of the interview with each participant, emphasizing especially our independence from the Norwegian government, and that the unique experiences and perspectives of the participants would be solicited in order to gain a deeper understanding of the experiences of Kurdish Iraqi immigrants as a whole.

6.2 Conditions for participation

Upon discussion with members of Iraqi communities regarding potential incentives for participation, I decided that all in-depth interview participants would be entered into a

drawing to win a 500 NOK gift card. Culturally appropriate foods and drinks were provided during the interviews, and expenses related to transportation were covered.

Upon the completion of the data collection phase, I also distributed an information packet to all of the in-depth interview participants. The packet included:

- Patient information pamphlets about some of the illnesses most salient to Iraqi immigrants, including depression, anxiety, diabetes, thalassemia, etc.
- Contact information and descriptions of a range of NGO's, including organizations for asylum seekers, a center for immigrant women, a crisis centers, etc.
- Contact information and descriptions of governmental health- and social services
- Information about patient's rights, including the right to an interpreter

The packet also included a letter, which reiterated gratitude to the participants for participating and listed the contact information of the principle investigator and the research assistant, should they need to contact us. We also made sure to explicitly state that all of the participants received exactly the same information, in order to avoid giving the impression that we were attempting to diagnose participants or otherwise or insinuate that they were in particular need of a given piece of information. All of the contents of the information packet were translated to the participants' native languages.

6.3 Potential risks and benefits of participation

Prior to the onset of recruitment and data collection, we outlined the potential risks and benefits of partaking in the research, as well as how we planned to minimize them. According to Omer and Ruyter [71], risks and benefits can be roughly divided into four thematic categories, consisting of physical, psychological, social, and economic risks and benefits. Each of these thematic categories can, in turn, be classified as direct or indirect risks and benefits to the participants. The main risks and benefits of participation in our project were direct psychological risks and benefits to the individual participants, and indirect social risks and benefits to Iraqi Kurds at large, which we will discuss in the following section.

6.3.1 Direct psychological risks and benefits

Most of Iraqis in Norway have a refugee background, and as indicated in the literature review, there is a high prevalence of post-traumatic stress disorder, anxiety, and depression among Iraqi asylum seekers and refugees in general [34,37,72]. Given this vulnerability, we deemed that severe emotional distress or even re-traumatization were possible risks of participating in the interviews, during which sensitive issues would be discussed. Some of the main measures taken to reduce this risk included informing the participants about the main themes of the interview at an early stage, presenting this risk in the informed consent form and the discussion surrounding it, and carefully introducing sensitive questions. Also, as mentioned previously, we would typically end each interview with a short debriefing, during which the participants were asked how they felt (See discussion on reflexivity and participant welfare in section 4.6.1). However, many participants reported feeling relieved, good, or like weights had been taken off their shoulders after the interview. This leads us to the potential psychological benefit of participating in the interviews, namely the potential therapeutic of participating in qualitative research [64]. Though one cannot guarantee that participation in the interviews will have a therapeutic effect, the positive feedback that we received indicated that several participants did experience some psychological benefit from participation.

6.3.2 Indirect social risks and benefits

Despite good intentions, it is possible that the results of the study will be interpreted in a way that encourages simplistic or erroneous interpretations of Iraqis' experiences. This, in turn, could create or further strengthen existing stereotypes about Iraqis or immigrants at large, which would pose an indirect social risk to Iraqis. Though it is difficult to control how the study will be interpreted, used, or misused once it is made public, we will do our best to communicate the results to the media in a nuanced and careful manner. Still, though we must be humble in acknowledging the potentially limited scope and implications of the research, it is also possible that wide dissemination of the research findings will contribute to a more nuanced understanding of Iraqis' experiences among healthcare workers, policy makers, and the community at large.

6.4 Additional ethical issues

In addition to the anticipated risks of participating outlined above, we encountered several ethical dilemmas throughout the research process, which we will briefly discuss in the following.

6.4.1 Responding to interpersonal violence

One of the most acute ethical situations we experienced arose when a female participant brought to our attention that her husband exercised intimate partner violence against her, both psychological and physical⁴. The woman cried and was shaking as she shared her story, and we focused on consoling and calming her until she was visibly calmer and reported feeling better.

The principal investigator and the research assistant, both of whom had extensive experience working with women exposed to interpersonal violence, discussed the case thoroughly after the interview. Given our pledge of secrecy, we were not in a position to intervene in the woman's situation. As she and her husband had a child, however, we questioned how our roles as researchers would coincide with the Law for Healthcare Personnel⁵, which obliges healthcare personnel to report any suspected abuse of children to child protection services. The woman had not given any indication that her child was experiencing physical or psychological violence, however, we wanted to explore further what our obligations would be, should such violence come to light. Thus, we initiated contact with the Regional Committee for Medical Research Ethics, who responded by recognizing their lack of expertise in this field, and therefore recommended that we contact competent organizations in this field and discuss the case with them. They also mentioned critical dialogue between the principal investigator and the supervisor (second author) as an integral part of dealing with this case.

⁴ As detailed by the woman, the abuse included restrictions on movement, threats, systematic abusive language, and mentions of physical violence in the past (indicating potential physical violence at present moment).

⁵ Law for healthcare personell §33 states: "Uten hinder av taushetsplikt etter § 21 skal helsepersonell av eget tiltak gi opplysninger til barneverntjenesten når det er grunn til å tro at et barn blir mishandlet i hjemmet eller det foreligger andre former for alvorlig omsorgssvikt, jf. lov om barneverntjenester § 4-10, § 4-11 og § 4-12."

We followed the Ethical Committee's advice, and engaged in dialogues with a crisis center and a center for immigrant women. Upon further reflection, we reached the conclusion that we would engage in a dialogue with the woman experiencing violence in the second interview. Proceeding carefully, we reiterated that we would continue to honor a pledge of secrecy; however, if we were made aware that a minor was being abused, we would be obliged to notify child protection services. Still, we emphasized that our primary concern was to learn about her experiences with healthcare services, and that she was free to decide what she did and did not want to share with us. Upon the completion of the second interview, we carried out a thorough debriefing session, discussing the woman's feelings and fears, and helping her explore different options for seeking help and documenting the abuse, should she want to seek help. As we received no indication that the child was experiencing interpersonal violence, we took no further action in this matter.

6.4.2 Access to healthcare

Another ethical issue arose when a male respondent revealed that he was an undocumented migrant, and that he did not have membership in the NIS, which was specified in the informed consent form as a requirement for participation. Upon learning this, we contacted the nurse at the asylum reception center, who informed us that in practice, undocumented migrants living at the asylum reception center receive free access to healthcare services, as the asylum reception center make their appointments and pays for their healthcare expenses. Thus, we decided to keep this person as a participant. We informed the Regional Committee for Medical Research Ethics about this decision, who in turn, accepted the inclusion of the participant.

This event alerted us to the fact that some of the participants may not have understood the terminology used in the informed consent form. We considered changing our routines in terms of explaining and discussing the informed consent form in more detail with each participant. However, as this was the last participant to be accepted into the study, and we had no indication that any of the other participants were undocumented, we did not pursue any further action in this matter.

7.0 Dissemination of findings

We have written an article with the aim of publicizing it in an international peer-reviewed scientific journal. If accepted, such a publication would help ensure broad dissemination in scientific communities and would hopefully contribute to more research and attention to immigrants' perceptions and experiences with healthcare services in Norway and to the migrant health field at large.

We also intend to write a report with a description of the findings and possible implications for policy and practice. This report will be distributed to all organizations and institutions with whom we have cooperated, as well as other organizations and branches of government or health care institutions that may benefit from learning the results. We also intend to distribute a similar report (translated to Kurdish by the research assistant) to the participants of the research. In addition, the research assistant will call the illiterate participants to explain and discuss the research findings with them to ensure understanding by all participants.

**PART II: Article submitted for publication to
BMC Health Services Research**

We expected paradise”: Iraqi immigrants’ perceptions and experiences with healthcare in Norway

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Abstract

Background

Cultural competence has been demonstrated to be of great importance in the delivery of quality healthcare to immigrants. Iraqi immigrants experience a high burden of illness; however, little research exists regarding this group's interactions with the healthcare system. Thus, we aimed to explore Iraqi immigrants' perceptions and experiences with Norwegian healthcare.

Methods

We conducted 20 in-depth interviews and one group interview with Iraqi immigrants in the greater Oslo area. Interviews were analyzed using Systematic Text Condensation. We also carried out 15 informal key informant interviews.

Results

We found that Iraqi immigrants generally evaluated Norwegian healthcare positively, compared to healthcare in Iraq. In-depth interviews with Iraqi immigrants revealed the following experiences with Norwegian healthcare: unmet expectations; distrust toward general practitioners; and perceived differential treatment, substantiated by concrete examples of differential treatment. However, respondents hesitated to voice criticism toward healthcare providers. We also identified several barriers to care, including intimate partner violence, inadequate provision of trained interpreters, limited health literacy, language gaps, and cost of outpatient care. Social support through advocacy and provision of information facilitated access to care.

Conclusions

Despite generally viewing Norwegian healthcare positively, Iraqi immigrants are subject to multiple barriers to care, including language gaps and inadequate provision of interpreters. Concrete examples of differential treatment in healthcare settings emerged; yet, participants hesitated to voice criticism, which may be partly explained by "The Happy Migrant Effect." As perceived differential treatment was exacerbated by unmet expectations, divergent past experiences, and limited health literacy, efforts to reduce perceived differential treatment ought to include provision of adequate information and discussion of patients' expectations, particularly in the establishment of GP-patient relationships.

Background

Cultural competence has been demonstrated to be of great importance in the delivery of quality healthcare to immigrants [1]. Research on immigrants' health around the world reveals complex relationships and heterogeneous findings [3]; however, reviews indicate that migrants experience reduced access to healthcare, substandard health outcomes, and high prevalence of psychopathology [4,5]. Though literature regarding immigrants' perceptions of and experiences with healthcare is scant and dominated by quantitative studies, some qualitative studies highlight the following findings: unmet expectations; difficulties adjusting to long waiting times; lack of confidence in healthcare providers; and barriers to care, including language gaps, cost of care, and limited health literacy (i.e. limited ability to comprehend and act on health information) [14,15,25,73,74]. Qualitative studies have yielded differing findings regarding whether immigrant perceives or experience differential treatment or discrimination [15,23,25].

Theoretical frameworks shed light on the dynamic natures of health systems and experiences. Kleinman's concept of culturally influenced "explanatory models," i.e. thought patterns regarding the etiology, symptoms, and cures of illness, underscore how migrants' and providers' differing conceptualizations of illness and health might influence their encounters [44].

In Norway, a rapid influx of immigrants in the past decades has called for policy makers and healthcare providers to implement equitable and culturally competent care [27]. While some initiatives have been implemented, Norwegian healthcare workers still perceive that they have insufficient knowledge and resources to meet the needs of migrants [29,30].

The Norwegian healthcare system is modeled on the "gatekeeping" system, in which each resident is assigned a registered general practitioner (GP), in attempts to ensure continuity of care, effective provision of services, and appropriate referrals. The National Insurance Scheme assures universal healthcare; however, limited co-payments for outpatient care apply, and dental and physiotherapy care is generally not covered.

Estimates indicate that over 4 million Iraqis are displaced worldwide, and, in Norway, the 20 000 Iraqi immigrants constitute the fourth largest immigrant group [26,32]. Though

scant literature exist regarding Iraqi immigrants in Norway, one landmark study, which compared immigrant groups to each other and the population at large, found that Iraqi immigrants were among those with the most frequent use of GP, emergency room (ER), and specialist services, and had the largest burden of illness [57]. When examined by gender, findings also reveal that Iraqi women made up the immigrant group with the largest burden of illness, most frequent use of health services, and the greatest need for interpreters.

Based on the magnitude of the Iraqi Diaspora in Norway and globally, as well as the large burden of illness among Iraqi migrants, we aimed to explore Iraqi immigrants' perceptions and experiences with healthcare services in Norway.

Methods

Setting, sampling, and recruitment

The study was conducted in the greater Oslo area, where immigrants and children of immigrants make up roughly one third of the population [75]. As evidence indicates that some health beliefs and behaviors differ between ethnic groups [44,45], we decided to restrict our sample to ethnically Kurdish Iraqis, who make up roughly half of the Iraqi immigrants in Norway [43]. However, for the purposes of this paper, we will refer to "Iraqis," which includes, but is not limited to Kurdish Iraqis.

We recruited 15 key informants, whom we identified as having extensive experience with Iraqi immigrants, by virtue of their profession or community involvement (See Table 1). As we sought to elicit a wide range of perspectives, key informants included health care personnel, community members and leaders, asylum reception center staff, interpreters, and immigration officials.

At an early stage in the research process, key informants acted as gatekeepers to Iraqi communities and helped identify salient themes to be explored. Later in the research process, informal key informant interviews were primarily used to contextualize emerging findings from in-depth interviews.

In order to obtain a broad range of views among those participating in in-depth interviews, we conducted purposive sampling, seeking maximum variation in respondents' gender, age, years spent in Norway, highest completed education, and immigration status. The first author (JDH) carried out recruitment, primarily targeting non-profit and community organizations. Contact persons at recruitment sites distributed informational materials in the participants' native languages, detailing the purpose and the voluntary nature of the research project. Potential participants filled in contact forms, which were returned to the first author. Upon making contact with potential participants, four persons declined participation, predominantly due to lack of spare time. A total of 14 persons accepted participation (See Table 2), of which five men and five women took part in two in-depth interviews each. Additionally, four female respondents participated in an in-depth group interview, conducted to further explore some findings from the individual interviews.

Ethical considerations

The study was approved by the Regional Committee for Medical Research Ethics and the Norwegian Social Science Data Services. We provided informed consent forms to all those participating in in-depth interviews in their native language, encouraging participants to discuss questions and concerns, continually stressing the confidential and voluntary nature of the research. All respondents gave their written informed consent to participate before each interview.

Data collection

The first author conducted all of the interviews; 12 of the interviews, the group interview included, were conducted with a female interpreter present. The interviews typically lasted between 1.5-2.5 hours and were conducted at locations of the participants' choice, such as participants' homes or a private room at the University of Oslo. We employed a thematic interview guide, allowing us to add and subtract emerging themes to the interview guide throughout the data collection phase. As a starting point, we chose three main themes, derived from the research questions, including: participants' perceptions and experiences with healthcare in Iraq, participants' perceptions and experiences with healthcare in Norway, and participants' perceptions of illness and health. With participants' consent, all in-depth interviews were recorded. Observations regarding participants' body language and other non-verbal cues were also noted. The second interviews were typically conducted 4-6 weeks after the first interviews. The repeated encounters aided in establishing rapport and

allowed us to present our understandings of the participants' statements, encouraging respondents to reject, accept, or expand on our interpretations. Data collection ended when we reached data saturation.

The first author also carried out 15 informal key informant interviews, which centered on the key informants' expertise. Extensive notes were taken during and after key informant interviews, and were subject to critical discussion with the second author (MS).

Analysis

The first author analyzed the data using systematic text condensation inspired by Giorgi and modified by Malterud [62,76], consisting of the following steps: (i) reading the material with an open mind, noting main themes; (ii) identifying units of meaning regarding Iraqi immigrants' perceptions and experiences; (iii) grouping the units of meaning into codes and summarizing the contents of each code; (iv) writing synthesized descriptions, based on the units of meaning, of Iraqi immigrants' perceptions and experiences. All of the interviews were transcribed verbatim and coded based on emerging themes and categories. An independent interpreter translated two randomly chosen interviews to enhance validity. The first author and the interpreter worked closely together in the analysis stage, listening through interviews together, negotiating meaning and challenging each other's interpretations of the data, solving disagreements by consensus. Main themes from informal key informant interviews were also integrated during the analytic process.

We strove to maintain reflexive mindsets, that is, self-conscious awareness of how knowledge is produced, and the influence of power, social position, and researchers' interests in all stages of the research [77]. Both authors are ethnically Norwegian women, have extensive experiences with multicultural populations, and have academic backgrounds in international health, as well as social sciences (JDH) and nursing and anthropology (MS). We kept field journals, performed negative case analyses (i.e. deliberately seeking contradictory evidence), and engaged in reflexive dialogues, also with the interpreter, a female Kurd, who fled from Iran to Iraq at a young age and had several years of experience interpreting in health and social sectors.

Results

We found that Iraqi immigrants generally evaluated Norwegian healthcare positively, compared to healthcare in Iraq. In-depth interviews with Iraqi immigrants revealed the following experiences with Norwegian healthcare: unmet expectations; distrust toward general practitioners; and perceived differential treatment, substantiated by concrete examples of differential treatment. However, respondents hesitated to voice criticism toward healthcare providers. We also identified several barriers to care, including intimate partner violence, inadequate provision of trained interpreters, limited health literacy, language gaps, and cost of outpatient care. Social support through advocacy and provision of information facilitated access to care.

Healthcare in Iraq

In order to contextualize Iraqi immigrants' experiences with Norwegian healthcare services, we collected in-depth accounts of respondents' perceptions and experiences with health services in Iraq. Most participants grew up in families of low socio-economic status, and their experiences with Iraqi healthcare services were largely influenced by whether they could afford private healthcare. The few Iraqis who managed to pay for private services enjoyed direct access to specialists, minimal waiting time, and high-quality care. The majority of the participants, however, utilized public healthcare, which was inexpensive, but often required long waiting times. Most participants were generally satisfied with Iraqi healthcare services and viewed Iraqi doctors as highly competent. However, major barriers to care existed in Iraq, including cost of private healthcare, authoritarian attitudes among healthcare staff, and denial of access to treatment on the basis of patients' political views. In fact, several respondents shared stories of family members that had been denied healthcare services on the basis of their political affiliations, and that suffered severe illness or death as a consequence.

Perceptions of healthcare services

Overall, respondents generally agreed that, compared to the quality of public healthcare in Iraq, Norwegian healthcare services were of satisfactory quality. In-depth accounts, however, revealed some evidence of negative perceptions and experiences.

Most Iraqi participants reported expectations of great affluence and immediate access to high-quality health services in Norway. *"I thought it was paradise!"* claimed one woman in

her 30's, detailing her expectations of Europe prior to migration. For some, the desire for migration to Europe was driven by an expectation that their chronic illnesses, such as disability or musculoskeletal issues, might be cured, often leading to a perceived lack of concern from healthcare providers when expectations were not met. This was also the case for a woman who, as she waited for surgery, visited her GP frequently in efforts to persuade the GP to expedite the referral process:

"If I don't go to the doctor and pester him [and] say I'm in pain [...], he doesn't care, he never answers me. Maybe five more years I will be on the waiting list." (W 30's)

Similarly, other respondents also expressed that long waiting times for referrals indicated that GPs were not concerned with the welfare of the patients, which contributed to distrust toward GPs. Rooted in past experiences of direct access to specialists, respondents also questioned the qualifications of GPs and their ability to properly diagnose a wide range of illnesses, including illnesses specific to Iraqi populations. Others contended that GPs' tendency to give patients' sick leave rather than to immediately initiate tests also evidenced GPs' insufficient ability to identify diseases. Despite distrust and dissatisfaction, however, many participants hesitated to voice criticism directly to healthcare providers, as exemplified by this woman's reluctance to tell her GP that she was dissatisfied with the care she received:

"But I couldn't tell her [the GP] directly. [...] I didn't want to say the truth. I said [to myself]: Ok, I won't say anything; I'll just go ahead and switch GPs." (W 30's)

This pattern was also present in other respondents' illness narratives, as unmet expectations and distrust toward healthcare providers contributed to frequent re-registering with new GPs.

While some Iraqi participants expressed that they did not wish to criticize Norwegian healthcare, key informants shared that colleagues from various health fields often viewed Iraqi immigrants as voicing more criticism and exhibiting more "demanding behavior" than patients at large. Consequently, healthcare providers typically responded with surprise and frustration, believing that Norwegian health services were of such quality that immigrant patients coming from poor countries would be more grateful and present less demanding behavior than patients at large.

Perceived differential treatment emerged as another central theme. Especially among recently arrived immigrants, the dissonance between expectations of immediate access to care and the opposing reality of long waiting times, coupled with limited health literacy, contributed to a perception that healthcare providers treated immigrants differently than non-immigrants. One man who had lived in Norway for several years revealed his initial response to this discrepancy:

“Back then I thought: We are foreign, that’s why they do those things. But today I think that it’s not that way. The system is like that, you know.” (M 30’s)

As he spent more time in Norway, he familiarized himself with the system and adjusted his expectations, eventually dismissing the hypothesis that healthcare providers treated immigrants differently than non-immigrants. Among other respondents, a perception of differential treatment prevailed over time. Several concrete examples of differential treatment also emerged. A few key informants who coordinated GP care for refugees and asylum seekers expressed that some providers exhibited hostile attitudes toward immigrants, and that individual variations existed regarding the degree to which GPs provided equitable services for immigrant patients. For example, key informants claimed that they had observed a tendency for some GPs to spend less time with immigrant patients, neglect necessary tests, or dismiss immigrant patients’ concerns. In-depth interviews also yielded examples of differential treatment, including accusations that patients were liars and that they were pretending to be ill in order to get sick leave. One man also mentioned an episode where he had visited emergency care and the physician refused to communicate with him. Pondering the physician’s motivations for his actions, he reflected:

“R: I don’t know if I he didn’t like immigrants, or....I don’t know. I don’t want to accuse him of anything. (laughs)

I: How did that make you feel?

R: I felt that I...That I’m an immigrant. [...] Because I’m not Norwegian, that’s why he did it. Maybe. Or maybe not.” (M 40’s)

Though he questioned the motives of the physician, the man later concluded that he did *not* view the incident as discriminatory. In fact, a pattern emerged in the interviews, as participants typically shared experiences and perceptions of differential treatment; however, when later asked directly if they had been subjected to discrimination, most would negate such an experience.

Barriers to access

For some female participants, intimate partner violence was a major barrier to access to healthcare, as physically and psychologically abusive husbands restricted or dominated their medical visits, conversations with healthcare providers, and treatment regimes. One woman in her 50's reported feeling "caged," as her husband denied her access to healthcare services, threatening: "*You have to obey me, like in Iraq.*" This woman, like several others, wanted to seek medical help, but fear of husband retaliation, the stigma and shame of divorce and violence, and the belief that GPs were not competent conversation partners regarding abuse were powerful barriers against doing so.

Lack of provision of trained interpreters and the use of family members as interpreters also emerged as central barriers. According to respondents, it was common for husbands to act as interpreters for wives that arrived on family reunification. While some women expressed finding safety and comfort in having their husbands act as advocates and interpreters in initial encounters with the healthcare system, this was not a sentiment shared by all. In particular, one woman, whose abusive husband insisted on acting as interpreter for her, was rendered helpless in the face of her son's illness, as her husband refused to allow healthcare staff to speak to her through an interpreter:

"If something would've happened to my son then, I wouldn't know what the reason was at all, because they [the doctors] didn't explain anything to me. They tried to explain to me, but he [the husband] refused." (W 20's)

Thus, as healthcare workers succumbed to the husband's wishes not to provide an interpreter, they failed to detect or intervene with the abuse, leaving both the woman and her son at risk of serious injury.

Limited health literacy, limited knowledge of patients' rights, and language gaps also threatened Iraqis' access to healthcare services. Especially among participants with limited

language skills, a sense of powerlessness prevailed, as they expressed inability to comprehend and navigate the Norwegian healthcare system. Some participants also shared that they had been injured at their workplace during their first few years in Norway. However, due to limited knowledge at the time, they no longer had the right to claim compensation, which limited their access to a host of health and welfare programs.

Lastly, the cost of outpatient care, and particularly dental and musculoskeletal care, served as barriers for access to care. One male participant lamented that despite experiencing pain, he would delay seeking dental care until his next visit to Iraq, scheduled for a few months later, because he could not afford dental care in Norway. Some participants also noted that difficulties paying for healthcare were exacerbated by low income. For one family prone to chronic illness, in which neither parent had steady employment, the wife expressed that the cost of care surpassed the constraints of their budget:

“We don’t have any money for doctors’ visits. [...] And that’s why I cancelled the last appointment with the doctor.” (W 20’s)

Though the cost of care prevented some Iraqis from seeking health services, other respondents argued that Norwegian healthcare services were affordable, relative to Norwegian wages.

Facilitators to access

Social support in the form of advocacy and provision of information often played a crucial role in determining Iraqi immigrants’ access to healthcare services in Norway, especially among the illiterate and newly arrived migrants. Given the differences in structure and organization of the Norwegian and Iraqi healthcare systems, receiving adequate information was essential to access to care. However, participants reported receiving little or no information about the healthcare system in their native tongue upon arrival in Norway. Those living in asylum reception centers typically received information and practical assistance in accessing healthcare services and requesting interpreters. Some Iraqis had family members in Norway prior to migration, and most of these respondents received information about what to expect early on, allowing them to adopt more realistic expectations toward the healthcare system.

Discussion

Though respondents were generally satisfied with Norwegian healthcare, experiences and perceptions of differential treatment, unmet expectations, and distrust emerged. Intimate partner violence, inadequate provision of trained interpreters, limited health system literacy, language gaps, and cost of outpatient care were identified as barriers, while social support through advocacy and information facilitated access to care.

Corroboration with literature and implications for practice

Qualitative studies on immigrant groups from diverse settings corroborate several of our findings, including lack of trust in GPs, unmet expectations, limited health systems literacy, as well as a host of financial, structural, and personal barriers to care [14,16,25,54,74]. Our findings also reflect Kleinman's dynamic model of healthcare systems, as exemplified by how Iraqi patients' and healthcare providers' differing perceptions and expectations influenced their encounters [44].

Patient satisfaction has been demonstrated to play a central role in compliance, continued use of health services, and maintenance of patient-provider relationships [78]. A quantitative landmark study noted that eight in ten Iraqis were satisfied or very satisfied with healthcare services in Norway [57]; however, our in-depth accounts revealed experiences and perceptions of differential treatment, unmet expectations, and distrust. This reflects a common tendency for quantitative studies of patient satisfaction to yield more positive findings than qualitative studies [9].

Another possible explanation for the discrepant findings of participants' satisfaction lies in a construct called "The Happy Migrant Effect" [79]. This construct, developed on the basis of an Australian study, purports that immigrants with little to no English language skills may be reluctant to voice their concerns with the healthcare system or to claim their healthcare rights, despite experiencing negative events. This effect is typically influenced by perceived powerlessness, cultural norms that prescribe acceptance or politeness, patriotism for the new country, and a positive comparison of healthcare services in the host country. Additionally, past experiences of close ties between healthcare providers and authoritarian governments, may lead some immigrant patients to refrain from voicing criticism toward healthcare providers for fear of punishment. We therefore found that "The Happy Migrant Effect" provides a plausible explanation of some Iraqis' reluctance to assert their rights and

voice negative experiences with healthcare services directly to health providers. Further research on immigrant populations ought to consider the possible impact of this construct.

Qualitative studies have yielded differing conclusions regarding whether or not immigrant patients perceive or experience discrimination or differential treatment, and this complexity was reflected in our findings as well [15,23,25]. Though some participants hesitated to characterize their experiences as discriminatory to the researchers during the interviews, social desirability bias and elements of “The Happy Migrant Effect” may have discouraged participants from doing so. Our findings suggest that some Iraqis likely experience discrimination, and that perceptions of differential treatment are exacerbated by unmet expectations, divergent past experiences, and limited health literacy. As perceived discrimination is associated with poor mental and physical health outcomes [80], further research is needed to explore this complex concept in light of immigrants’ experiences.

Our data suggesting that social support, through provision of information and advocacy, may help immigrants adjust their expectations, is also corroborated in literature that highlights the malleable and complex nature of expectations [52]. Some evidence also suggests that expectations may be a possible predictor of patient satisfaction [50]; however, this hypothesis has been contested [51]. Nevertheless, it is reasonable to expect that provision of adequate information and adjustment of expectations may be central components in improving patient satisfaction among Iraqi immigrants in Norway. Thus, it may be advisable for healthcare authorities to sustain and improve efforts to distribute health information in immigrants’ native languages, as well as to encourage providers to discuss patients’ expectations for care, particularly in the establishment of GP-patient relationships.

Our study also sheds light on the potentially destructive effects of permitting family members to act as interpreters; however, little research has explored the link between intimate partner violence and use of partners as interpreters. Evidence suggests that inadequate provision of interpreter services compromises the quality of care for patients in need of interpreters, and particularly for patients with mental disorders [21]. Given Iraqis’ high levels of psychopathology and high self-reported need for interpreters, sustained and increased efforts to ensure adequate provision of trained interpreters for Iraqis is an urgent

matter. Further research is also needed to explore intimate partner violence and the immigrants' use of partner as interpreters in healthcare consultations.

Strengths and limitations

We took several measures to enhance the validity of our study, including performing negative case analyses, engaging in reflexive dialogues between researchers and with the interpreter, and ensuring the quality of the interpreter's work through independent translations of two interviews. The internal validity of our findings is also strengthened through the use of repeated interviews, which allowed us to discuss and negotiate our interpretations with participants. As we integrated the interpreter into the research team, the interpreter took on the role of a "cultural broker," aiding in contextualizing findings and comprehending unstated or subtle cultural meanings [65]. Moreover, as our interpreter was an Iranian native, but had lived several years in Iraq, she held a dual role as both "outsider" and "insider," which aided in developing trust and openness among participants [68].

Though the study is restricted to one geographical area and a small sample of one immigrant group, we suggest that our findings can be "extrapolated" to inform the provision of culturally competent care among immigrants in similar settings [81].

Recall bias and social desirability response bias were potential limitations of the study. Efforts to counteract these biases included deliberately inviting in-depth accounts of past experiences, rather than asking direct question or soliciting broad, generalized statements. Additionally, conducting repeated interviews also aided in developing rapport, permitted in-depth knowledge of respondents' perceptions and experiences, and enabled us to challenge seemingly contradictory statements.

With the exception of informal key informant interviews with healthcare workers, this study did not solicit healthcare providers' perspectives; however, existing literature on health care staff's views on working with immigrant populations does provide a basis for contextualizing our findings.

Our exploratory research design with repeated in-depth interviews provides a new perspective to a field otherwise heavily dominated by quantitative studies. By interviewing

Iraqis that had lived in Norway for various lengths of time, we also viewed immigrants' experiences from both prospective and retrospective angles.

Conclusions

Despite generally viewing Norwegian healthcare positively, Iraqi immigrants are subject to multiple barriers to care, including language gaps and inadequate provision of interpreters. Concrete examples of differential treatment in healthcare settings emerged; yet, participants hesitated to voice criticism, which may be partly explained by "The Happy Migrant Effect." As perceived differential treatment was exacerbated by unmet expectations, divergent past experiences, and limited health literacy, efforts to reduce perceived differential treatment ought to include provision of adequate information and discussion of patients' expectations, particularly in the establishment of GP-patient relationships.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

JDH conceived the study, conducted the interviews, analyzed and interpreted the data, and wrote the article. MS supervised the study, and contributed to the study design, analysis and interpretation of data, as well as the preparation of the article. Both authors read and approved the final manuscript.

Acknowledgements

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Tables

Table 1 - Characteristics of key informants (n=15)

Characteristic	No.
<u>Gender</u>	
Male	7
Female	8
<u>Occupation/community role</u>	
Asylum reception center staff	2
Community organization members	4
Health- and social sector staff	3
Interpreters	2
Immigration directorate staff	2
Non-profit organization staff	2

Table 2 - Characteristics of in-depth interview participants (n=14)

Characteristic	No.
<u>Gender</u>	
Male	5
Female	9
<u>Age</u>	
19–30 years	5
31–50 years	7
>51 years	2
<u>Years spent in Norway</u>	
<6 years	6
7–10 years	6
>11 years	2
<u>Residency Status</u>	
Asylum seekers	1
Refugees*	7
Family reunification visa	6
<u>Occupation</u>	
Unemployed	3
Unskilled manual labor	3
Skilled labor	3
Student/secondary education	5

*Including quota refugees and previous asylum seekers

Appendix I: Informed consent, individual interviews

PART I: Request for participation in a research project

Background and purpose

I am a master's student at the institute for health and society at the University of Oslo. The purpose of my research is to gather knowledge about Kurdish Iraqi immigrants' views and experiences of primary health care in Norway. The aim is to improve health services for Kurdish Iraqis and for immigrants, asylum seekers, and refugees in general. I am an independent student, and I do *not* have any attachments to the Norwegian government.

What does the study entail?

I will ask you to participate in up to three interviews, which will take place in a location of your choice. You may choose to have a translator present or not. I will ask you about topics related to your experiences with health care in your home country and in Norway, and your health before, during, and after migration to Norway. You can choose not to respond to any question.

In addition to individual interviews, I will also conduct group discussions with Kurdish Iraqi immigrants.

Potential risks and benefits

Speaking about these topics may bring forth bad memories or even make you re-live traumas. This is a potentially serious risk of participating. I will give you information about how and where to access health services. All the information will be treated strictly confidentially and your name will be kept separately from the rest of the data material. I will do my best to protect your anonymity, however, I cannot guarantee that it will be impossible for those who read the final report to recognize unique stories or statements that you have provided.

What will happen to the information that you provide?

The interview records will only be seen by me and my research assistant. The project will finish by June 30th 2011, but you might be asked to participate in a follow-up study. For this reason, the data will not be destroyed until December 31st 2014. The final results will be published in either a master's thesis paper or as an article in a scientific journal. These documents are both accessible to the public. The Data Protection Official for Research have been notified about the project.

Insurance

You must be covered by the Norwegian Insurance Scheme to participate in the research project.

Voluntary participation

Participation in the study is voluntary. You can withdraw from the study at any time and without stating any particular reason. This will not have any negative impact on you, your relationship to your healthcare provider, or your residence status in Norway.

If you wish to withdraw your consent or have questions concerning the study, you may contact the project leader, Janne Dale Hauger at [contact information removed]. The project supervisor, Mette Sagbakken, can be contacted at [contact information removed].

PART II: Declaration of Informed Consent

I have read the above information (or I have heard the information that was read out to me) and I have understood everything. I, hereby, give my full consent to participate in the study by signing (or marking) this form. I understand that I can withdraw from the study at any time, and that I can choose to have all (or parts of) of the information I have given withdrawn from the study.

Date and signature of the participant:

Date and signature of the researcher:

Date and signature of witness (if applicable):

Appendix II: Informed consent, group interview

PART I: Request for participation in a research project

Background and purpose

I am a master's student at the institute for health and society at the University of Oslo. The purpose of my research is to gather knowledge about Kurdish Iraqi immigrants' views and experiences of primary health care in Norway. The aim is to improve health services for Kurdish Iraqis and for immigrants, asylum seekers, and refugees in general. I am an independent student, and I do *not* have any attachments to the Norwegian government.

What does the study entail?

I will ask you to participate in a group discussion (1 to 2 hours) together with other Iraqi refugees/asylum seekers. An Arab/Kurdish speaking person will facilitate the discussion. You will be asked about topics related to your views on health care in your home country and in Norway, and how the health care system could be improved. In addition to these group discussions, I will also conduct group discussions with Norwegian healthcare workers and individual interviews with Kurdish Iraqi immigrants.

Potential risks and benefits

There are minimal risks associated with participating in this study. All the information will be treated strictly confidentially and your name will be kept separately from the rest of the data material. I will do my best to protect your anonymity, however, I cannot guarantee that it will be impossible for those who read the final report to recognize unique stories or statements that you have provided.

What will happen to the information that you provide?

The interview records will only be seen by me and my research assistant. The project will finish by June 30th 2011, but you might be asked to participate in a follow-up study. For this reason, the data will not be destroyed until December 31st 2014. The final results will be published in either a master's thesis paper or as an article in a scientific journal. These documents are both accessible to the public. The Data Protection Official for Research have been notified about the project.

Insurance

You must be covered by the Norwegian Insurance Scheme to participate in the research project.

Voluntary participation

Participation in the study is voluntary. You can withdraw from the study at any time and without stating any particular reason. This will not have any negative impact on you, your relationship to your healthcare provider, or your residence status in Norway.

If you wish to withdraw your consent or have questions concerning the study, you may contact the project leader, Janne Dale Hauger at [contact information removed]. The project supervisor, Mette Sagbakken, can be contacted at [contact information removed].

PART II: Declaration of Informed Consent

I have read the above information (or I have heard the information that was read out to me) and I have understood everything. I, hereby, give my full consent to participate in the study by signing (or marking) this form. I understand that I can withdraw from the study at any time, and that I can choose to have all (or parts of) of the information I have given withdrawn from the study.

Date and signature of the participant:

Date and signature of the researcher:

Date and signature of witness (if applicable):

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