



The road to equitable healthcare: A conceptual model developed from a qualitative study of Syrian refugees in Norway

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ABSTRACT

Background: Refugees in high-income countries face barriers to healthcare access even when they have the same rights and entitlements as the host population. Disadvantages in healthcare access contribute to differences in health outcomes and impact acculturation. This study explores perceived changes in health status and experiences with the Norwegian healthcare system of Syrian refugees living in Norway, using a trajectory perspective. **Methods:** We conducted 15 semi-structured interviews in April 2020 among purposefully recruited adult refugees from Syria resettled in Norway. Interviews were carried out in Arabic and analysed with Systematic Text Condensation using NVivo software. We used Lévesque's access model and Edberg's migration trajectory perspective as theoretical frameworks. A conceptual model was developed – The Migrant Sensitive Access Model – that highlights the factors contributing to a positive versus negative healthcare journey.

Results: Findings were summarized under three main themes: *changes in health and well-being, expectations, and trust*. Perceived changes in health status and attributed causes for change were related to the resettlement phase, gender, and were highly informed by pre-migration and migration experiences. The users' perception of the caregiver, communication, and time were identified as key factors in the care-access journey in inspiring trust or distrust in the caregiver.

Conclusion: Syrian refugees in Norway appreciate the Norwegian healthcare system but are impeded in their access to care. Many of the barriers can be bridged during the doctor-patient interaction with a diversity sensitive caregiver. The model we propose gives a comprehensive overview of key areas determining the healthcare experience of this population. The results of this study can be useful to policymakers and healthcare providers when addressing disparities in healthcare access for forced migrants.

1. Introduction

With an unprecedented number of people on the move, the health of forced migrants has become a vital global public health concern (The Lancet Public, 2018). While the right to health and access to healthcare is embedded in a number of international laws and agreements (Declaration of Human Rights), protecting these rights in practice remains a challenge. Resettlement countries are obliged to secure health systems that deliver appropriate and equally accessible services. Yet, forced migrants in high-income countries are often at a disadvantage when accessing the health care they are legally entitled to, despite resettling in welfare states with publicly funded health services.

Healthcare inequities are found when there are preventable systematic variations in access caused by socio-economic conditions, migrant status, or ethnicity (Rechel et al., 2013). Measuring access to healthcare is, however, complex. Access relates directly to the need of the patient, and the use of health services should be proportional to this need. Hence, proxies for access such as healthcare utilization, time until treatment, and mortality rates are often used (Kumar and Diaz, 2019). Prior research has found that migrants in several high-income countries display different patterns of healthcare utilization than the non-migrant population, representing both overuse and underuse (Graetz et al., 2017; Klein and von demKneesebeck, 2018; Rosano et al., 2017). Similarly, the use of healthcare services also varies depending on the reason for

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migration and length of stay in the receiving country (Diaz and Kumar, 2014). These differences may indicate inherent barriers to access. However, measuring access through utilization rates and indicators cannot sufficiently answer questions on satisfaction, whether needs are met, and the quality of care received. Forced migrants may be at particular risk of having unmet needs and receiving poorer quality of care due to numerous obstacles such as language and communication barriers, low health literacy, sociocultural norms, lack of trust and perceived discrimination (Brandenberger et al., 2019; Bhatia and Wallace, 2007). For instance, disparities in referral rates based on migrant background could indicate poorer quality of care (Lyrtzopoulos et al., 2012). While socio-economic status can account for much of the documented differences in healthcare utilization, previous research points to migrant background as an independent risk factor for health disparities (Sundquist, 1995).

Insufficient access to healthcare has been identified as one of several concurrent post-migration stressors causing progressive deterioration of health (Marmot et al., 2008) and, subsequently, in the loss of the health advantage as outlined in the *healthy migrant theory* (Diaz et al., 2015). While the relationship between health and acculturation is not fully understood, it is generally recognized that good health is both an essential element for integration and an outcome of successful integration (Rechel et al., 2013; Chen et al., 2017). Hence, the healthcare system can either amplify or weaken this process. Given its fundamental role in both short- and long-term health outcomes, healthcare access is acknowledged as a key social determinant of health, and the consequent reduction in inequities as a principal element in health system performance (Marmot et al., 2008).

Studies on forced migrants' access to healthcare often fail to sufficiently integrate the different factors affecting migrants' health in the different phases of their life course: preceding and accompanying migration and after resettlement (Spallek et al., 2011). The home-country setting, including the healthcare system, plays a role in shaping migrants' perceptions and expectations of the receiving country's healthcare system. During migration and in transit settings, healthcare access is often limited and scattered and may be accompanied by fear of detention or deportation. Upon resettlement, the values of the caregiver and migrants' health beliefs, among other factors, influence migrants' perceptions of the health services being reliable and acceptable, impacting future healthcare behaviour.

Forced migrants in Norway have the same rights and entitlements to benefits and welfare services as the non-migrant population. The Norwegian healthcare system offers universal health coverage with small out-of-pocket expenditures. Primary care with GPs in the front act as gatekeepers to the next echelons of medical care, regulating access to hospitals and specialists. A large majority of forced migrants in Norway meet their GP within the first year after arrival, often as their first point of healthcare contact (Haj-Younes et al., 2021). Interpreters are available for patients with poor language proficiency.

Current research largely focuses on describing the barriers to healthcare forced migrants face regarding restricted rights to entitlements, covering temporary post-migration stressors such as resettlement challenges, often from the provider's perspective. Few studies have focused on settled refugees where many of the temporary challenges are eliminated. There is also a lack of research on the migration trajectory, exploring the process from arrival to later resettlement, and the multifaceted correlation between past migration experiences and future healthcare access. The aim of this study, therefore, is to explore settled Syrian refugees' perceived health status, health status change, and experiences with the Norwegian healthcare system post-migration, employing a migrant trajectory perspective. In doing so, the research allows for exploring the nexus between health and healthcare access among forced migrants in relationship with the acculturation processes.

1.1. Theoretical framework

We used Lévesque et al.'s conceptualization of access to healthcare as a theoretical input to support the research (Levesque et al., 2013). This framework integrates the attributes of both providers (supply side) and individuals (demand side), each identified by five dimensions. The five dimensions on the provider side are: approachability, acceptability, availability and accommodation, affordability, and appropriateness. The five dimensions on the user side are: ability to perceive, ability to seek, ability to reach, ability to pay, and ability to engage. The model also adds a time perspective and presents each dimension sequentially, attempting to mirror the patient's healthcare journey. However, many of the stages of the model are inter-related, and the movement between stages is continuous and fluid. Healthcare access is defined as "the opportunity to reach and obtain appropriate health care services in situations of perceived need for care" (Graetz et al., 2017).

The migrant trajectory perspective is based on Edberg et al.'s work (Edberg et al., 2011) drawn from a socio-ecological model, which explains that while several factors contributing to refugee health disparities have been identified, the interaction of these multiple contributing factors is seldom considered. In all stages of the migrant trajectory (pre-, peri- and post-migration), factors add on and interact to shape later healthcare behaviour, operating together as a dynamic system over time. We adopted this framework to emphasize how the migration experience informs later healthcare access, impacted by geography and time.

2. Methods

2.1. Study design and participants

This study is part of a larger study titled *Changing Health and health care needs Along the Syrian Refugees' Trajectories to Norway* (CHART), which investigates health among Syrian refugees in Norway. We conducted 15 semi-structured in-depth telephone interviews with adult Syrian refugees (seven men, eight women) in April 2020. Participants were between 24 and 68 years of age (average 47 years), settled in seven different municipalities (both rural and urban) at the time of the interviews. Their length of stay in Norway ranged from 1 to 9 years (average of 4.5 years). The sociodemographic characteristics of the participants are presented in Table 1.

2.2. Data collection

We identified the participants through contacts in the Syrian community with subsequent snowballing (Biernacki and Waldorf, 1981) and proceeded with purposive sampling to ensure diversity in characteristics and background (gender, age, education, geographical location, and years of stay in Norway). For instance, we started in the city of Bergen, where we have an established network within the Syrian community, and approached relevant participants directly. Eight participants were recruited this way. We then asked participants already enrolled if they knew a Syrian refugee living in a rural area, or some of the other characteristics we were looking for to ensure diversity. Seven participants were recruited this way. We selected Syrian nationals who arrived in Norway after 2010 as asylum seekers, refugees, or family reunification to a refugee family member. All participants were settled in a municipality, which gave them equal rights to entitlements as Norwegian citizens. We developed questions based on knowledge from previous quantitative research (Haj-Younes et al., 2020) and used an interview guide with open-ended questions with additional probes for deeper exploration. All interviews were conducted by the first author (JHY) who is fluent in the first language of the participants (Arabic) and shares their Syrian background. The interviewer is a female medical doctor pursuing a Ph.D., with experience of working in a refugee health centre. JHY was not familiar with any of the participants before the study. The

Table 1
Sociodemographic characteristics.

Participant	Gender	Year of birth	Level of Education (years/level)	Arrival year Norway	Marital status	Municipality
1	F	1956	12 - secondary	2015	Widowed	Urban
2	M	1973	12 - secondary	2017	Married	Urban
3	F	1952	10 - secondary	2016	Married	Urban
4	M	1971	6 - primary	2017	Married	Rural
5	F	1989	15 - university	2014	Married	Rural
6	F	1978	12 - secondary	2016	Married	Rural
7	F	1996	15 - university	2017	Married	Rural
8	F	1980	12 - secondary	2011	Married	Urban
9	M	1970	0 - no education	2018	Divorced	Rural
10	M	1968	9 - primary	2013	Married	Urban
11	F	1971	12 - secondary	2015	Married	Urban
12	M	1982	6 - primary	2019	Married	Urban
13	M	1977	11 - secondary	2015	Married	Rural
14	F	1954	11 - secondary	2015	Widowed	Urban
15	M	1972	9 - primary	2015	Married	Rural

interviews were carried out during the start of the COVID-19 pandemic, providing the rationale for the choice of interview method. The second author is an experienced qualitative researcher (EA), and the third (BK) and fourth (ED) authors are established researchers in the field of migrant health. The research team on this study thus offers a range of perspectives.

We developed an interview guide covering three main themes:

- 1) Changes in health during migration and after arrival in Norway.
- 2) Experiences with the healthcare system after arrival in Norway.
- 3) Trust and distrust in the healthcare system and healthcare providers.

The interview protocol is provided in [Appendix A](#). The interviews lasted approximately 40 min (range: 30–60 min). All the refugees who were contacted gave their consent and participated and no one dropped out from the study. After completing the interview, participants were offered a 150 NOK gift card as a token of appreciation for their time. Interviews were audio recorded, transcribed verbatim, translated by a professional translator, and cross-checked against the original recordings by the first author. Transcripts were not returned to the participants for comments or corrections. We judged the information power from the data as sufficient based on the concepts of sample and research question specificity, use of established theory, quality of dialog, and analysis strategy ([Malterud et al., 2016](#)). The broad, exploratory cross-case analysis called for a sample large enough to create sufficient information power. The sample of participants was established with specific aspects of variation in mind. With support from theoretical frameworks as well as strong and clear communication in the participants' first language, we regarded the information power in the transcribed interviews as sufficient to perform adequate analysis.

2.3. Data analysis and developing the model

We analysed the data using an inductive iterative approach, using Systematic Text Condensation ([Malterud, 2012](#)), a method well-suited to thematic cross-case analysis. The analysis followed a four-step process: (i) reading the transcripts repeated times to familiarize with the data; (ii) identifying text units (units of meaning) relevant to our aim and encoding them with codes derived from the data (not determined a priori or mapped to the theoretical models); (iii) interpreting, condensing and abstracting similarly coded text units for a common meaning; and (iv) summarizing the content within the coded groups into descriptions of the participants' perspectives and experiences. We used the theoretical frameworks as « analytical lenses » throughout the analysis. From the thematic analysis, we were able to identify factors that impact the care-access journey of our sample, providing the framework for the conceptual model developed in this study. Data were initially analysed by JHY, supervised by EA, and thereafter

independently analysed by ED. The process of data analysis was regularly discussed within the research team and all the authors participated in the final analysis. Consensus on final theme categorization was reached as a team. We used NVivo software to manage the data.

2.4. Ethical considerations

We obtained ethical approval from the Regional Committee for Medical and Health Research Ethics- South East Norway (ref. no. 2017/377). Participants were briefed verbally on the study and subsequently received electronic written informed consent in Arabic. Participants gave verbal confirmation of having read the informed consent form and of their participation prior to the commencement of each interview. Data was stored on a protected server.

3. Results

This research aimed to explore forced migrants' perceptions of their health and potential changes in their health with migration as well as experiences with the Norwegian healthcare system. We identified several important aspects related to health and access to healthcare and present these as three themes: *changes in health and well-being, expectations, and trust*. We then used the data to elaborate a conceptual model that highlights factors that contribute to the care-access journey of forced migrants. To understand experiences with healthcare access, it is important to first gain insight into the participants perceived health status and healthcare needs ([Aday and Andersen, 1974](#)). Thus, we start by presenting the first theme relating to changes in health and well-being along the migratory path, followed by two themes that deal with health care access more specifically. The concept of acculturation is reflected across the data. Quotations are assigned pseudonyms.

3.1. Changes in health and well-being: A process

3.1.1. Initial stressors after arrival

Several participants described the challenges they face in terms of their health and healthcare needs depending on the length of stay in Norway. For many, the initial period after arrival was characterized by mental stress over the status of their asylum application. Decline in health was attributed to stressful lives in the refugee reception centres and struggles with non-permanent housing. In addition, challenges with language barriers, understanding a new culture, or difficulties navigating and negotiating a new societal and healthcare system were highlighted. Participants mentioned numerous types of stressors, often pointing to the sum of stressors as the reason for the perceived decline in health. However, amid this chaos, participants also emphasized positive feelings of having hope for a better future for themselves and their families, of new opportunities, and the feeling of safety. One participant

shared how the initial period after arrival was mentally stressful, so much so that her distress manifested in physical symptoms:

“Ever since I came to Norway, maybe because of mental pressure and stress, and because we were in an asylum center for several months waiting for a residence permit with a lot of thinking and so on, I began to have problems with my stomach and it only got worse, it started with a burning sensation in the upper abdomen and it made me unable to sleep ...” (Leena, female, aged 31 years)

The effect of non-health policies on health, as exemplified in the above quote, was frequently mentioned. Some participants emphasized how external factors, such as change in climate, environment, and food culture affected their health in various ways. Strange food and the inability to buy desired food, due to either lack of accessibility or lack of money, meant for many a drastic change in dietary habits. One participant elaborated on this, explaining that she wanted to eat vegetables as she used to do in Syria, but expensive vegetables and a low income made her unable to keep a healthy diet. Another participant described the additive stressors of initial arrival by highlighting non-permanent housing in addition to food insecurity resulting in physical symptoms:

“... when I first came, I was healthy and eventually I started not eating. The food was strange for us, we were in a shock somehow, we lived in an asylum center too, but steadily my body became slim and I felt that when I was walking I couldn't feel my own body ...” (Sana, female, aged 49 years)

Geographical location in Norway influences service provision, and rurality impacts several services including healthcare, with implications on the ability to reach healthcare. This was highlighted by some participants who explained how living remotely influenced their social well-being, with limited public transport and longer distances to schools, the GP office, and hospitals in addition to poor support from persons with similar background. For some participants, the Norwegian climate and clean air were perceived as having a positive impact on their health. For a few others, however, the cold climate was a negative, as it caused body pain, joint pain, and dry skin. The importance of language proficiency on health was highlighted by two older participants, who explained how they asked for permission to attend Norwegian classes as this had an impact on their social well-being, even though they were exempted from this due to age. Language was important both in non-health related arenas, as well as in healthcare, pertaining to the ability to perceive and reach healthcare.

3.1.2. *New challenges in the later resettlement period*

After the initial arrival period, the shock and emergency response of being new seem to resolve, and a better understanding of the country's societal structure facilitates everyday life including healthcare access. However, new challenges relating to social exclusion and exclusion from the labour market appeared with accompanying health effects. Male participants in particular described their mental and physical struggle with unemployment and inactivity leading to weight gain and an unhealthy lifestyle.

“My health has worsened, has become a lot worse, but it is not because of the doctors here, we are simply used to work in our home country, you know how it is in Arabic countries and I am a physical worker, not an office worker, but now we have to attend school and are often at home.” (Ammar, male, aged 49 years)

In contrast, some female participants found the change in their traditional role—from being a homemaker in Syria to being active outside the home in Norway—challenging.

“Ever since I came to Norway, I feel I have days when I don't have the capacity to do anything and feel depressed and there are days when I feel good ... in Syria, we were not used to being sent to work or go to

school, us housewives, not those who work and have jobs, we as housewives ... I realized that I get exhausted and depressed at times and I am tired, I can't handle more, but sometimes I pray to God to make us stronger ...” (Reem, female, aged 42 years)

Loss of status and social position, particularly among males, affected mental health, self-esteem, and social well-being negatively. This appeared to be more prominent among the highly educated, experiencing a bigger loss. Overall, there were no clear gender differences in perceived decline or improvement in health trajectories after arrival, however, the attributed reasons for the change were noticeably gender related. Some also correlated past experiences, and exposures pre-migration with their current health status, for example by mentioning physical and mental wounds from the war or poor nutrition over time. Several participants mentioned either having no changes in health or experiencing an improvement in health after arrival. This perception of an upturn was attributed to relief, security, improved living standard, and easier access to different types of services.

3.2. *Expectations*

Diverging expectations emerged, rooted in the healthcare system known to the participants from their country of origin impacting health beliefs. This was outlined by descriptions and comparisons between the Norwegian healthcare system and the one known from before, here exemplified by a comment from a female participant:

“... I do not feel that they have as much experience and are as skilful as the doctors we have seen in Syria” (Leena, female, aged 31)

Expectations were also shaped by previous experiences, rumours, and anecdotes, in some cases acting as a deterrent to future health seeking. Expectations were not always met. Almost all the participants expected to get painkillers, antibiotics, or other medication when in contact with a healthcare provider. To get “something” was a minimum. One participant reflected on this with an open mind, noting that the way she used to get prescriptions with ease in Syria might not be correct. She explained how it was difficult to not receive what you were used to and how it might affect the elders in their community who were less able to adjust. Another participant, also noting these differences in healthcare systems and cultural beliefs, was unsure about what to think:

“... but sometimes when you want antibiotics, they [the doctor] won't listen, I don't really know if they are the ones being right or if it is just us being used to antibiotics ...” (Yara, female, aged 64)

Referral to specialists was another subject of mismatched expectations; many participants were used to consulting a specialist without referral in Syria. Hence, the gatekeeping role of the GP was unfamiliar, contributing to unfulfilled expectations.

Another important topic of discussion during the interviews was cultural differences in seeking healthcare. For the participants, when to seek care and the perceived non-acceptance of seeking care for simple conditions such as a fever were significant issues. One father explained that he preferred to seek care when his child had a fever, arguing that he is not a doctor and is afraid his child might suffer severe harm or even die if he does not take action. He explained that if he proceeded to seek care in such a scenario, he would feel bad about breaking Norwegian cultural norms, and “they” would view him as abnormal and disrespectful. This ambivalence on when to seek care appeared to be more prominent among the less educated and the ones with shorter duration of stay.

A majority of participants repeatedly pointed to the long waiting time in both primary and secondary care settings as a major obstacle to accessing healthcare. The waiting time was an unaccustomed experience and, in many situations, it was perceived as problematic.

“A difficulty I have seen is, for example, when you are ill and you need to go to the doctor and if they don’t find an appointment they make you wait for a week, ten days or two weeks ... it’s difficulties like these we meet because you somehow manage to recover before you get an appointment.” (Reem, female, aged 42)

3.3. Trust and distrust

Most participants trusted the Norwegian healthcare system and Norwegian healthcare providers. This trust is grounded in participants’ perception of humane, honest, and respectful treatment from Norwegian healthcare providers and past positive experiences. Several portrayed a process of building trust alongside positive experiences:

«You can say that my confidence has changed from when we came to Norway and now. We were used to taking medicine in our home country but here they [the doctors] say no, you do not need it in your situation ... maybe the way I reacted was because I was in a new society with cultural differences, but I thought to myself that this was maybe wrong of them ... but with time this thought has changed because I have been exposed to several health problems and it has, thank God, gone well. This increased my confidence in them» (Leena, female, aged 31)

3.3.1. The perception of the caregiver

For some participants, being listened to and being understood were just as important as physical care. This was particularly emphasized among female participants. For some male participants, the providers’ skills, and ability to give a prompt diagnosis inspired confidence. One participant explained that the reason he trusted Norwegian doctors was because they were “honest and tell you immediately if there is something wrong”. For several participants, the Norwegian healthcare system excels over others because of the humanitarian approach of the system and its caregivers. There is no differentiating between patients based on ethnic background.

“... they do not differentiate between Arabs and Norwegians, they treat everyone equally, and they are very kind and do not let you push yourself to cope with things that are beyond what you can handle. If you are in pain, they try to make things easier for you, even with when it comes to just talking, that is, not just with medication.” (Dalia, female, aged 24 years)

Both the ability to perceive and the ability to engage in healthcare require trust. The lack of trust in the healthcare system was based on participants’ negative experiences, perceived racism and discrimination, poor communication, lack of time, and, to some extent, the perceived inexperience of the healthcare provider. The experiences of racism and discrimination were mixed and occurred in some participants’ narratives, often expressed implicitly in statements like “the treatment I received was good considering I am an Arab” and “I am not Norwegian, so I have to wait until I almost die to be able to get treatment”. Others highlighted the exact opposite experience, the feeling of being accepted regardless of migrant background. Fear of discrimination in combination with poor communication also appeared in emergency care settings. Several participants described being overwhelmed by difficult questions when contacting pre-hospital emergency care by phone (calling 911). They feared not receiving help if they did not give the right answers. Some participants shared how they had to communicate with the emergency medical dispatcher through their children. A number of participants felt exceptionally vulnerable engaging with an unfamiliar system and not knowing what to say in a time-critical emergency to be able to receive the care that was needed.

“... we called the ambulance and you have to explain things to the ambulance and answer questions, even a doctor would not have been

able to answer those questions the ambulance is asking, you have to check the pulse and see how he is breathing, if I knew all those things then clearly I wouldn’t have called.” (Ammar, male, aged 49 years)

One participant described his fear of being discriminated against in an emergency setting because of his background. According to him, the first thing the healthcare worker will do is search for your personal identification number and they will know that you are not Norwegian-born. Others reported positive experiences in emergency settings where the ambulance came promptly and they received good treatment at the hospital. In several of these accounts, the person calling the ambulance was fluent in Norwegian (a neighbour, friend, or teacher) and the health problem was well-defined (symptoms of stroke and heart attack).

3.3.2. Communication

Communication emerged as an important topic across the data. Good communication was attributed to the caregivers’ abilities to listen and willingness to understand, even with the use of non-verbal communication. Poor communication was related to increased misunderstandings and a poorer doctor-patient interaction, contributing to distrust. Poor communication was highlighted regardless of the use of interpreters. As one participant explained, when using an interpreter, you must make sure that they understand and deliver your message correctly. For some participants, an interpreter worked well when explaining simple medical conditions. However, for complex and multifaceted medical conditions, where effective communication was fundamental, referring to effective communication being more than mere words, an interpreter was insufficient.

“What I have seen are problems with the language. You have to be very competent in the language. Because with interpreters, as I told you, the interpreter does not always give the right picture to the doctor. It’s not that if you have a headache, well then you get a pill ... this is not where the problem lies, but it is about having special diseases and complex problems and if the doctor does not understand you properly then you will not get the right treatment.” (Ali, male, aged 50 years)

3.3.3. Time

Several participants mentioned time during consultations as crucial in the healthcare experience. Lack of time during the consultation was an obstacle, explaining that consultation with interpreters takes more time, often not accounted for in the appointment scheduling. Participants felt restricted and demotivated to discuss complex problems or mentioning several health issues in the consultation.

“I do not feel that I can feel free [to express myself] when I am at the doctor’s due to time.” (Ali, male, aged 51 years)

Alternative health-seeking strategies were described when experiencing unmet needs, such as contacting a Syrian doctor outside Norway for advice. Some described seeking out-of-hours care when the waiting time for an appointment at the GP was perceived as too long. The rejection from the healthcare system by negative experiences seemed to be amplified by rejection on other non-health related arenas, such as in education or the labour market, resulting in distrust in the Norwegian system in general. A negative view was often expressed as comparisons, such as “Syrian doctors are better” or “the Syrian educational system is better”.

4. The Migrant Sensitive Access Model

Based on the data on health care access represented in two themes, expectations and trust, a conceptual model was developed (Fig. 1). The conceptual model outlines a pathway from expectations about health-care to experiencing trust or distrust in the system and its providers by

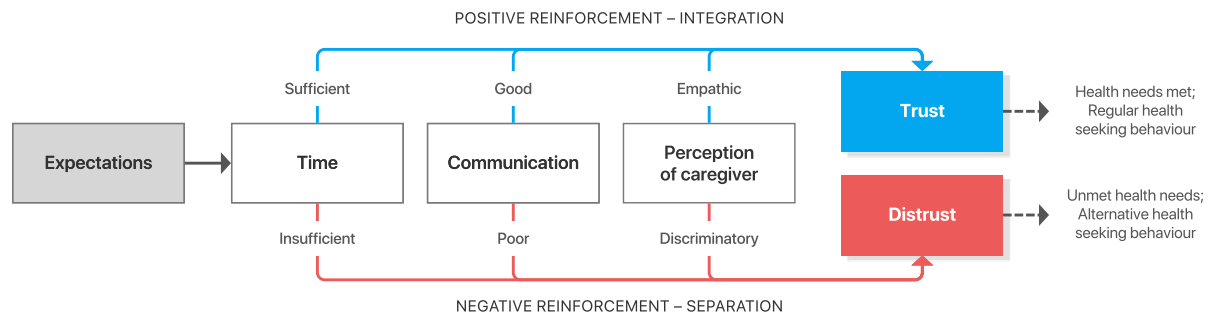


Fig. 1. The Migrant Sensitive Access Model (insert figure here).

crucial elements along the way. We have highlighted three elements in the proposed pathway; *the perception of the caregiver, communication, and time*, grounded in our data. These elements can either serve as barriers or as facilitators to achieving trust. In the element we have called the *perception of the caregiver*, we find characteristics participants have identified as important in inspiring confidence and create mistrust. In the *communication* element, participants shared their experiences with what poor and good communication entail. Lastly, the concept of *time*, both in terms of consultation time and time during interaction with the caregiver, emerged as fundamental in the care-access experience.

The point of the model is to highlight how different parts of the care-access process interact to reach the endpoint of either fulfilled or unmet healthcare needs, and the parallel process of healthcare seeking and acculturation. As shown from our data, negative experiences from healthcare seeking can amplify an already existing feeling of separation from society leading to more distancing, which in turn can have an impact on how health needs are met and the use of regular and alternative healthcare services. In contrast, positive experiences follow a positively reinforcing root based on trust and integration. A positive experience enhances trust and motivates further use of the healthcare system which in turn strengthens the acceptance of the Norwegian system and society.

5. Discussion

We explored Syrian refugees’ experiences with changes in their own health and access to healthcare services after forced migration to Norway. Our principal findings were categorized into three themes: *changes in health and well-being, expectations, and trust*. Our results suggest that health challenges for refugees are deeply intersected with the acculturation process, underpinning the different phases of the post-migration trajectory manifest in different challenges during early and late resettlement. In early resettlement, participants experienced temporary stressors connected to asylum-seeking and adapting to new environments. Later, challenges relating to social exclusion emerged, centred on the relationship of the migrants with the labour market.

We also identified a gender aspect in the types of challenges met. Some of the female refugees struggled with the transition from being at home in Syria to having many responsibilities outside the home in Norway, while at the same time adjusting to a new culture—a type of role overload and/or role conflict resulting in a change in family dynamics (Van de Velde et al., 2013). In contrast, male refugees identified unemployment and inactivity as the main cause of the deterioration in their health. Even though there is a recognition in the literature of the importance of gender differences in shaping migration experiences (Llácer et al., 2007; Jarallah and Baxter, 2019), there is a lack of knowledge on how this affects the resettlement process and its relation to later health outcomes.

Health status change along the migratory path is highly linked with access and use of healthcare services, following parallel trajectories. In the early resettlement period, the **approachability** and **ability to**

perceive dimensions in Lévesque’s framework were most dominant, with a focus on information and screening from the service side and knowledge of available resources and health literacy on the individual side. In this first dimension, we also find the concepts of expectations, trust, and distrust.

Within the framework of the migration trajectory approach (Edberg et al., 2011), pre-migration and migration experiences as well as sociocultural norms shape the expectations of the receiving country’s healthcare system. The concept of expectations draws on a large body of previous theorising within psychological research, placing expectations within the range of cognitive care and context effects (Blasi et al., 2001). This is also in accordance with the **approachability** dimension within Lévesque’s framework, which highlights the fact that previous experiences inform one’s perception of the healthcare system. Often, high expectations contribute to the feeling of mismatch and, subsequently, disappointment. In our sample, a mismatch in expectations was found in terms of services (lengthy waiting time, referrals to a specialist), in health paradigms (use of antibiotics and painkillers) and in sociocultural norms, as exemplified by the father who was deterred from seeking care because of the fear of how he would be perceived by others. The judged appropriateness to seek care pertains to the **ability to seek** concept that underpins the role of sociocultural factors in accepting the service (Levesque et al., 2013).

Likewise, trust emerged as a core concept in accepting and utilizing conventional health care in our data and is rooted in theories on patient centeredness and cultural competence (Laine and Davidoff, 1996; Campinha-Bacote, 2002). Enough trust in the services is a prerequisite for reaching out, and a trustful relationship with the caregiver is pivotal to further acceptance and maintenance of service use. A compassionate and empathetic disposition has previously been reported as an important aspect of the healthcare provider to increase a trustful relationship (Robertshaw et al., 2017). Trust is also a dimension within the concept of social capital, and high levels of trust have a positive impact on health and seem to buffer experiences of perceived discrimination (Lecerof et al., 2016). Similarly, social capital is fundamental in fostering resilience, a vital salutogenic resource among refugees. Our findings emphasize two aspects regarding trust. First, gaining trust in the Norwegian healthcare system is a stepwise, interactive process, often starting with distrust and gradually shifting to more trust when becoming familiar with the system. Second, a high level of trust was rooted in positive experiences, good communication, and humane treatment, and not exclusively in increased knowledge of the healthcare system.

On the other hand, distrust was founded in negative experiences including discrimination, lack of time, and poor communication. Manifestation and fear of discrimination and stigmatization based on migrant background were mentioned by some of our participants, especially in emergency care settings where help from Norwegian-speaking friends was commonly necessary. As stated by the World Health Organization, discrimination at the individual and institutional levels must be regarded as the fundamental cause of many health

problems (How health systems can ad, 2010). Evidence suggests that discrimination plays a central role in both physical and mental adverse health outcomes after resettlement (Agudelo-Suárez et al., 2011; Straiton et al., 2019) and has also been linked to substituting conventional healthcare with alternative healthcare among migrants (Bazargan et al., 2005). Additionally, discrimination in the resettlement period has been associated with a negative impact on trust (Straiton et al., 2019; Ziersch et al., 2020). Experiencing discrimination and stigma when accessing care may increase distrust and reinforce negative experiences rendering the healthcare inappropriate, underlined in the final step in the access framework: **appropriateness**.

Healthcare utilization is also influenced by how services are organized and whether they can be reached physically and on time, represented by the **availability and accommodation** dimensions in the access framework. Our participants highlighted waiting times as problematic. Delays in obtaining appointments are recognized as a deterrent to receiving care (Levesque et al., 2013). Long waiting times can be discriminatory and easily implemented and justified since they apply to all patients. Some participants, therefore, viewed the gatekeeping function in healthcare as a point of vulnerability to potential inequity in services, and yet expressed some kind of acceptance of inequity, as exemplified by the participant who pointed out that the care he received was not that bad considering he is an Arab.

The mismatch in expectations and failure to respond in a culturally sensitive way will create unmet needs, which in turn can lead to alternative health-seeking behaviour, as outlined in the last dimensions of the patient journey: **appropriateness and the ability to engage**. Despite the increased awareness of cultural sensitivity in recent years, research shows that medical doctors remain largely unprepared due to lack of training and assessment of cultural competence in medical education programmes (Sorensen et al., 2019) and call for more training and guidance (Robertshaw et al., 2017).

Interestingly, while the health system's ability to meet the needs of the participants improves with time, it appears to be primarily because the participants themselves change, not because the system changes to meet their needs. This link between health care access and acculturation is highlighted in the conceptual model introduced in this paper.

5.1. Strengths and limitations

Our sample engaged participants from urban and rural areas, from diverse educational backgrounds and with equal gender distribution. We did not use interpreters, allowing for direct communication in the participants' first language, which most likely had a positive effect on establishing trust and in increasing the reliability of the data by minimizing information lost in translation. We sought to verify data rigor by including two independent coding procedures and by using two theoretical frameworks to guide our understanding of the findings.

Results should, however, be interpreted keeping in mind the following limitations. Even though we used purposive sampling to achieve a diverse sample, we have not asked about legal status when arriving in Norway (asylum seeker, quota refugee, family reunification) to ensure diversity in migration trajectories, nor have we included any single persons (never married). The use of telephone instead of face-to-face interviews could contribute to apprehension in the interview situation and loss of non-verbal communication. On the other hand, the use of telephone interviews allows for more anonymity. The participants' average length of stay in Norway at the time of the interviews was 4.5 years, yielding the possibility of recall bias when describing past events, which in turn may affect credibility. This time aspect, however, enabled us to assess the acculturation process in relation to healthcare access in both early and later resettlement, and the gradual transition in between. The model developed is simplified, and we recognize that other factors contribute and interact to shape the care-access journey.

5.2. Implications

Findings from this study are highly relevant to understanding forced migrants' experiences and perceptions of the healthcare system. While sociocultural barriers are not generalizable, we believe some of our findings can be relevant for other receiving countries in terms of concepts, given the similar policies governing resettlement and healthcare access in high-income countries across the globe. From a trajectory perspective, gaps and difficulties in healthcare access can be addressed and tailored depending on the resettlement stage. We believe the findings of this study add to the knowledge base of refugee health and can be useful when implementing migrant-sensitive strategies and training for healthcare providers.

6. Conclusion

The road to appropriate healthcare access for a refugee is dynamic, closely interrelated to the acculturation process, and informed by pre-migration and migration experiences. To address inequities in healthcare in countries with universal health coverage, it is important to understand how barriers other than entitlements and affordability come into play in the care-access journey. Many of these barriers can be bridged by achieving a trustful relationship with the healthcare system and its caregivers. The conceptual model we offer – The Migrant Sensitive Access Model - highlights the key factors that shape the healthcare experience for refugees, resulting in either trust or distrust of the healthcare system.

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Authors' contributions

All authors contributed to the study conception and design. Material preparation, data collection, and analysis were performed by JHY and supervised by EA. ED conducted an independent analysis of the data. All authors participated in the later stages of data analysis. EA, BK and ED provided supervision, interpretation and critical revisions throughout the process. The first draft of the manuscript was written by JHY and all the authors gave feedback on previous versions of the manuscript. All the authors read and approved the final manuscript.

Declarations of competing interest

None.

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Appendix A. Interview guide

Experiences with seeking healthcare

I wonder how you have experienced the contact with the healthcare services after you came to Norway. Can you tell me about the last time you contacted the healthcare services?

- What was the reason behind the need for contact?

- How did you contact the healthcare services? (telephone, webpage, e-consultation, meeting up)
- How did you experience the meeting?
- Did they understand your need?
- Did you receive the help you were looking for?

People have different experiences when they contact the healthcare services, in the way they are met. How has this been for you?
Can you tell me about any such experiences?

- What kind of obstacles have you experienced?
- Do you have any good experiences with the healthcare services? Tell me!
- What has been useful?
- Do you trust that the healthcare services are trying to help you? Tell me!

How has your health been since you came to Norway?

- What has gotten better?
- What has gotten worse?

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