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Women's perception of healthcare in Kristiansand

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ABSTRACT

This comprehensive study delves into the intricate web of women's perceptions within the healthcare system in Kristiansand, Norway. This study has a comprehensive literature review that explores international experiences and Scandinavian focused experiences to highlight similarities and particularities of the region of the study. Drawing from the perspectives of Compassionate Care Theory, Foucault's Theory of Power, and Gender Theory, this research aims to shed light on the nuanced experiences and challenges faced by women in their interactions with healthcare providers, institutions, and the broader healthcare environment.

Through a qualitative approach, this study uses semi-structured interviews engaging women from immigrant and Norwegian backgrounds in Kristiansand. The findings aim to highlight the challenges women face in healthcare settings, offer recommendations for improving compassionate care, and identify potential areas for structural changes to create more equitable and gender-sensitive healthcare systems.

This research contributes to the broader discourse on healthcare provision and patient experiences by uncovering the multifaceted nature of women's perceptions in healthcare in Kristiansand. It underscores the need for healthcare systems to prioritize compassion, dismantle harmful power dynamics, and challenge stereotypes related to gender to create a more inclusive and responsive healthcare environment for women.

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1. INTRODUCTION

In contemporary society, women continue to face numerous challenges throughout their lifetimes. One of the most pervasive and deeply concerning obstacles is the presence of gender bias in their medical treatment. The lack of voice and mistreatment that women are often subjected to in healthcare settings can have a profound and long-lasting impact on their quality of life and overall well-being. This issue is not only detrimental to individual women but also has broader implications for society's health and welfare.

Therefore, it is of paramount importance to delve into the experiences and perceptions of women regarding their healthcare treatment to understand the extent of the problem and identify potential solutions. The existence of gender bias in various areas of life is an issue that can no longer be denied. The medical field is no exception, and there is ample evidence pointing to this and in the subject of the medical field, this bias can be described as "unequal access or treatment that is not justified on the basis of an underlying health condition" (Alspach, 2017, p. 10). This refers to the fact that despite the lack of any medical evidence, women are still treated differently than man and hence are not able to receive the same level of care, which is something that has also been argued by Hamberg (2008).

The consequences of gender bias in healthcare are far-reaching and profound. This difference in treatment can be done through a lack of diagnosis, counsel, or appropriate treatment (Alspach, 2017) and thus their health outcomes can be negatively affected, leading to prolonged suffering and reduced quality of life. As it will be shown in this thesis, research has shown that women often face longer waiting times, particularly in emergency care situations, (Ruiz & Verbrugge, 1997) despite the fact that they seek medical attention more frequently than men.

Once you discourage a group of the population from seeking care for their illnesses, this has a direct impact in their quality of life and can make them believe that they are not as important as others. Such delays in receiving proper medical care can have direct implications on the outcomes of women's medical treatments and even influence their willingness to seek timely care.

Gender stereotypes as well as cultural and societal expectations play a pivotal role in perpetuating these biases, further exacerbating the problem. The prevailing societal perception of women as dramatic or weaker can make it harder for women to assert their concerns and be taken seriously when displaying symptoms. Unfortunately, these stereotypes can lead to doctors dismissing women's symptoms as mere exaggerations, undermining their ability to be heard and receive appropriate treatment. This is a severe problem for women, as this type of

stereotype is very damaging to their ability to voice concerns and be taken seriously. The necessity for women to provide more substantial evidence of their symptoms compared to men to receive appropriate treatment is a defining factor in women's healthcare experiences (Walsh et al, 2019).

This reality significantly impacts women's perceptions of their ability to access treatment and may lead to a loss of trust in the healthcare system (Hertler et al., 2020; Ladwig et al., 2000; Vlassoff, 2007). Addressing gender bias in healthcare is an urgent and complex issue that requires in- depth research and examination. B understanding women's experiences and perceptions regarding their healthcare treatment, it is possible to gain valuable insights into the existing gaps and challenges within the healthcare system. This knowledge can be used to advocate for policy changes and improvements in healthcare practices to ensure equitable and compassionate care for all individuals, regardless of gender.

1.1 PROBLEM STATEMENT

Gender bias in the healthcare field is a pervasive issue that poses significant challenges for women in accessing proper medical care and diagnosis throughout their lives. Women often fface disparities in the level of care they receive compared to men, leading to potential health consequences and reduced quality of life. To receive appropriate treatment, women may need to be more assertive and active in advocating for their healthcare needs, a burden not necessarily faced by their male counterparts. However, not every woman is equipped or able to properly advocate and voice their concerns and face these challenges effectively, which can result in many difficulties for their quality of life. I will investigate how the women in Kristiansand feel towards this issue and if there any gaps that can be addressed to provide better medical treatment for the women of the city.

1.2 OBJECTIVE OF THE STUDY

In this study, I aim to investigate the sentiments of women in Kristiansand regarding gender bias in healthcare. By exploring their experiences and perceptions, I seek to shed light on the existing disparities and challenges they face when seeking medical care, particularly in differences between immigrant and Norwegian born women and what are some of the repercussions that it has on their lives. This research also aims to examine whether there are specific areas where improvements can be made ensuring more equitable and compassionate treatment for women in the city. Ultimately, the goal is to better understand women’s healthcare perceptions and advocate for possible improvements to it.

1.3 RESEARCH QUESTIONS

To address the complex issue of gender bias in healthcare treatment, this study will focus on the following research questions:

1. To what extent does women's perception of their medical treatment affect their quality of life?
2. To what extent do women in Kristiansand believe the medical treatment they receive is adequate to their needs?
3. Is there any difference in the perception of treatment between immigrant women and Norwegian-born women?
4. Is there a different in health seeking behavior between immigrant and Norwegian born women? Do immigrant women change their behavior after immigrating?

1.4 RESEARCH DESIGN AND SCOPE

This study will be conducted in the city of Kristiansand, Norway. Kristiansand's size and accessibility make it an ideal location for this research, as it offers ample opportunities to engage with diverse groups of women from different backgrounds. Given the nature of this study and the desire for in-depth insights, a qualitative research design will be employed. Specifically, semi-structured interviews will be conducted with selected participants, allowing for open and meaningful discussions. The interviews will be conducted in English to ensure consistency and avoid the need for translators, enabling a smooth flow of communication.

The sample will consist of women who meet the criteria of being over 18 years old, having lived in Kristiansand for at least three years, and possessing fluent or advanced English language skills. A purposive sampling method, specifically criterion sampling, will be used to select relevant participants who can offer valuable insights into the research questions. Thematic analysis will be employed to identify major themes related to women's perceptions of their medical care.

In the subsequent sections of this study, I will delve deeper into the existing literature on women's perception of healthcare treatment, focusing on both international experiences and studies conducted in Norway. Additionally, we will introduce the theoretical frameworks that will guide our analysis, and discuss the methodology in detail, including its strengths and limitations. By the end of this study, the researcher aims to provide valuable insights into the experiences of women in Kristiansand and contribute to the advancement of women's healthcare in Norway, advocating for an inclusive and patient-centered healthcare system that respects and meets the needs of all individuals, irrespective of gender.

2. LITERATURE REVIEW AND THEORETICAL FRAMEWORK

This section of the thesis will combine the literature review with the theories applied to the analysis. The idea to have both in a unified chapters stems from the believe that this can help enhance the coherence and structure of the work, allowing for the thesis to be situated within the broader academic context while simultaneously providing a theoretical underpinning for the research. By doing so, readers can more easily grasp the theoretical foundation upon which the research is built.

This section starts with a comprehensive literature review, divided into three separate parts in order to analyse the current literature from different perspectives. Firstly, there will be a review of the literature in a broader scope, followed by a review of the literature of the Scandinavian region, where the study takes place. The third part will then connect the previous two, demonstrating similarities and differences that exist in the literature and possible gaps.

Building upon this, the theoretical lenses for this study will then be approached, drawing upon insights gained from the literature and articulate the theoretical perspective that guides this research. This part will demonstrate theoretical concepts and relationships that will be explored in the study, creating a clear and structure foundation for the research questions.

This part will also be divided into three sections, each of them focused on a different theory that will be applied in the analysis and connecting them to each other. This section is a cornerstone in the thesis, as it will show how the theories interact with each other and with the literature review, establishing the basis for the analysis. The three theories will be: Compassionate Care Theory, Foucault's Theory of Power and Gender Theory, with a focus on stereotyping.

After these two sections are explored, a smaller section will then follow providing the theoretical framework and connecting the previous sections and describing the how they interact with each other. This part will be key to understanding the way the analysis will be performed.

Integrating the literature review and theoretical framework within the same chapter streamlines the research narrative, as it connects the established knowledge to the chosen theoretical approach, ultimately paving the way for the research methodology and analysis in subsequent chapters.

2.1 LITERATURE REVIEW

The evaluation of perception of medical care treatment has been a fruitful subject in many countries and the subject has been approached from different perspectives. Even

in Norway, there is an ample body of literature that discusses this issue. However, most of these studies in Norway focus on specific types of situations, such as women care during pregnancy (Amundsen et al, 2019; Bains et al, 2021a; Bains et al. 2021b), how immigrant women access information (Lien, 2021, Møen et al, 2017) or specific cases of asylum seekers or immigrants of a specific country (Straiton & Myhre, 2017; Straiton et al. 2019). While those are very important issues to be addressed, we cannot reduce women's experiences solely to these moments.

In addition, while there have been studies that focus on the perception of medical care as whole and they demonstrate that there is in fact a disparity between how men and women perceive their situations, these studies seldomly approach the situation from a gender perspective (Loikas et al., 2015; Gil-Lacruz & Gil-Lacruz, 2010; Juvrud & Rennels, 2017; Mello et al, 2019; Pinkhasov et al., 2010; Street Jr, 2002; Travis et al., 2012; Van Wijk et al., 1996) . They simply state that differences exist between men and women, but they fail to address the reasons that this exists. This is an important gap in this subject that this thesis hopes to provide some insight into it.

This is what this thesis will seek to address, how women in general view their care, with a focus on the Kristiansand city in Norway, and while the main goal of this thesis is to address the experiences of women regarding their healthcare treatment as a whole, there will also be a focus on possible differences between immigrant women and Norwegian born citizens. In order to do so, this chapter of the thesis will be divided into three main sections to address the literature on the subject.

The first part will focus on an international level of women's healthcare experiences and what previous studies have found, as it is important to understand that this issue does not exist solely in Norway and that in reality is something that women can face everywhere. This section will refer to different countries and different contexts in order to understand how women's experiences throughout the world vary or are similar. This is key to comprehend possible struggles that are universally faced by women everywhere.

The second part will focus on Scandinavian based studies to understand the literature that exists regarding the subject in the region as it is the focus of the study to better understand the situation in Norway. The decision to use studies on Scandinavia, which consists of Norway, Sweden and Denmark is due to the similarities that the countries possess and to provide a more ample literature review of the issue in the area. The objective of this is to contextualize the situation in the specific region in which this study is taking place, this is particularly important as Scandinavia is often regarded as a region in the

forefront of women’s issues and therefore it is expected that this is reflected in their perspective of their medical treatment. Therefore, this section hopes to highlight the existence of any struggles that women face.

Lastly, there will be a small section comparing the previous two and attempting to shed light on possible reasons for the differences and similarities that exist between experiences from women in the different contexts addressed in this thesis. This section will hopefully provide a good basis of knowledge for the analysis of the perspective of women in Kristiansand.

2.1.1 INTERNATIONAL EXPERIENCES

There are many factors that come into play when accessing the perception of healthcare treatment received. It is important to understand that there is more to the situation than specific cases or diseases can explain and while most studies regarding women and healthcare have a specific focus, this is not always reflexive of the overall picture. One factor is understanding the way that societal inequalities can affect physical symptoms displayed by people (Walsh et al, 2019), this is relevant as it directly affects treatment and how the medical professional addresses the situation at hand. Van Wijk et al. (1996) argues that the reason for inequalities in healthcare based on gender is supported by the fact that women are still subjected to disparities in their lives. Furthermore, throughout the world “women's health is susceptible to poverty, violence and lack of gender-specific facilities and research” (Chamberlain et al., 2007, p.76). Based on this is possible to infer that the number of obstacles that women must overcome to access their healthcare is disproportional to their male counterparts, and therefore their ability to receive the same level of treatment is often hindered by these factors.

There are different barriers to which women are subjected around the world regarding their access to healthcare and this has a direct impact on both their medical treatment and their perception of such. These barriers are usually a result of cultural inequalities and stereotypes (Van Wijk et al., 2016), as well as development of the country (Puentes-Markidez, 1992). Due to this is important to assess the context in which women are inserted and which pressures they are put under as it can have a significant impact in their health and their behaviour toward seeking medical care (Travis et al., 2012; Osamor & Grady, 2016; Puentes-Markidez, 1992).

Similarly, there is no denying that around the world there are different levels of autonomy to which women are subjected and different types of expectations that befall on them in different contexts. This is a fundamental aspect of their life, and it has consequences to their health and quality of life. Therefore, understanding the specific context and its effects is very important to discussing women health worldwide.

In many countries in the world, women are still heavily subjected to patriarchy and have their lives dictated by familial obligations. This means that their ability to make choices regarding their own health is often affected by this situation. In some cases, the pressure to have children is incredibly high and the inability to do so can lead to several problems to the women (Kothari & Sriram, 2022). In their study, Kothari & Sriram (2022) address the many pressures and difficulties that women in India face due to infertility and difficulties in getting pregnant. They state that there is a lack of autonomy for women to make informed decisions regarding their own body, which can lead to them being subjected to treatments that have high impacts on their health, but that the societal pressures can be so high that those women that fail to get pregnant are often shunned from others (Kothari & Sriram, 2022). Their study shows that women's autonomy is close to non-existent in these cases, and this affects their perception of how and why they should seek out medical care.

Another problem that the patriarchal societies can put women under is the expectations that they should be pure and therefore free of diseases that are commonly associated with a more vulgar lifestyle. This is the case of the women in Zimbabwe and their struggle with HIV (Gona & DeMarco, 2015). Due to the nature of the disease and how it is perceived in the society, women often delay seeking medical treatment for fear of how they will be viewed and stereotyped by others. There is a real fear regarding the opinion of others, to the point that women often ignore the signs of the disease and only seek out help once they are in dire need (Gona & DeMarco, 2015). This is directly related to the misogyny existent in their culture and the burdens that are placed on women. For them, their own health is less important than how society sees them and therefore their health seeking behaviour is heavily affected by societal expectations.

Another study conducted in Malawi by Madula et al. (2018) raised the issue that a lack of proper communication between healthcare providers and women during pregnancy contributed to maternal deaths and complications during childbirth. This demonstrates the persistent difficulty that women in less developed countries have in receiving proper medical care. In a time during which women are extremely vulnerable due to significant

changes happening in their bodies, they still need to face an added hurdle of verbal abuse by healthcare providers as well as language barriers (Madula et al., 2018), this means that these women often chose to not use the available medical facilities and subject themselves to higher risks.

It has also been found that in order to get treatment, women need to display more symptoms than men (Walsh et al, 2019: Attanasio & Hardeman, 2017, Oksuzyan et al., 2019), which means that the condition can have advanced more and also that it takes longer for treatment of women to begin to take place, meaning that it is often harder for them to receive proper care. In addition to this, it has also been found that women can take longer to report their symptoms to their doctor (Hadfield et al, 1996, Juvrud & Rennels, 2017; Mello et al., 2019) which can be explained by their fear of not being taken seriously. This can impact women's willingness to seek medical treatment as they think that their symptoms will be dismissed and therefore can cause even greater delays in treatment.

It has been strongly documented in cardiovascular treatment that men are much more thoroughly investigated and treated than women showing the existence of a persistent gender bias (Walsh et al, 2019), which means that it is harder for future patients to receive treatment as causes and types of treatment are not as thoroughly known. In accordance with this Walsh et al (2019) also found that there is evidence that women are consistently undertreated, and that this undertreatment leads to subsequent higher risk for other patients as the effects of diseases in women are neither well investigated nor studied.

This is in line with what was found by Hadfield et al (1996) and Evans et al (2022), in which conditions that affect only women, such as endometrioses, can take years to be identified, for women's symptoms to be taken seriously, which once more delays any type of treatment that they can receive. The delay in treatment directly influences women's quality of life as they often need to struggle for longer periods with symptoms of diseases (Hadfield et al, 1996, Evans et al., 2022) and therefore it is common that women must learn to live with varying levels of pain and discomfort due to lack of proper understanding and interest in their health, which has a direct and negative impact on their perception of healthcare, increasing the level of distrust that women have in their capability to receive proper care.

It is common that medical personnel have a wrong perception regarding the symptom burden of women which leads them to providing them with subpar treatment (Walsh et al, 2019; Samulowitz et al., 2018). Thus, women can feel unheard and dismissed, which once more can cause them to not seek medical treatment as often as men. This

difference in help-seeking behaviours can play a role in the existing gender gap in healthcare (Juvrud & Rennels, 2017), as it is easier to provide treatment the earlier symptoms are reported.

Another factor that plays an important role in women's medical treatment is the existence of gender stereotypes. There are different expectations in regard to how men and women should behave regarding preventive medical postures. This is highly evidenced when it comes to conception and pregnancy as demonstrated by Mello et al (2019). The types of scrutiny to which women are subjected to is much higher than men and there is significant more pressure put on women and their behaviour (Mello et al, 2019), this can cause undue stress on women and place a heavier burden on them, making it more complicated for them to actively take steps to deciding their medical situation.

All of the mentioned above demonstrate that there are several different factors that can affect women's perception of their healthcare treatments. This shows the level of vulnerability that women are exposed to in regard to their medical care. It is therefore essential that those issues are brought to light as the way women see their healthcare heavily influences their quality of lives. In order to show provide more insight into the different difficulties faced by women, the next part of this section will focus on specific problems raised above to address each of them more thoroughly.

Women's experiences with medical diagnosis and treatment

Women's experiences with medical diagnosis and treatment are influenced not only by gender bias but also by societal attitudes towards women's health concerns. Research has shown that women often face challenges in having their symptoms taken seriously by healthcare professionals (Barker, 2011; Hoffmann & Tarzian, 2001; Werner & Maltervud, 2003, Walsh et al, 2019; Samulowitz et al., 2018). Symptoms that are predominantly experienced by women, such as chronic pain, are sometimes dismissed or attributed to psychological factors, leading to delays in diagnosis and appropriate treatment (Hadfield et al, 1996, Evans et al., 2022). This fact highlights an important barrier that women face when seeking proper medical care and that it heavily impacts their perceptions of it.

Moreover, the tendency to downplay women's health concerns can also impact their psychological well-being. Women may experience frustration, anxiety, and a sense of helplessness when their symptoms are not acknowledged or taken seriously (Tait et al., 2009). This emotional burden can further exacerbate the challenges they face in accessing proper healthcare and create more distance between them and their doctors. The lack of consideration

towards women’s concerns and voices is still predominant in the medical field and in order to curb them, the need for women to become their own advocates can create more pressure for them.

Cultural Influences on Women's Health Behavior

Cultural norms and practices can significantly influence women's health behavior and attitudes towards seeking medical care (Mochache, et al., 2020). In some cultures, women are expected to prioritize the health and well-being of their family members over their own. This self-sacrificing attitude can lead to delays in seeking medical attention, as women may neglect their own health needs to prioritize others.

Furthermore, as it was demonstrated both by the Zimbabwe case (Gona & DeMarco, 2015) and by the Indian case (Kothari & Sriram, 2022), there are still certain expectations that are placed on women in certain cultures as to how they should behave and what they should achieve in order to be considered as good standing members of society.

Promising Initiatives and Interventions

Despite the challenges, there are promising initiatives and interventions aimed at addressing gender bias in healthcare and improving women's experiences. For example, some healthcare systems have implemented gender-sensitive training for healthcare professionals to raise awareness of gender-specific health issues and reduce bias in treatment (Lindsay et al., 2019). Even though these initiatives are still in early stages, they are an essential component of developing a better environment for women. This can be a game changer when it comes to women’s perception of their medical treatment.

Additionally, efforts to improve women's access to healthcare information and education can empower them to make informed decisions about their health (Nasrabadi et al., 2015). In some regions, women-led organizations and advocacy groups have played a significant role in raising awareness about gender bias in healthcare and promoting policy changes to address the issue. Such initiatives are instrumental in fostering a more inclusive and patient-centered healthcare system that meets the diverse needs of women. While this is an incredible step towards diminishing mistreatment of women in the medical sector, it also still puts the burden on them to advocate for themselves, which can be dauting for many.

2.1.2 SCANDINAVIAN EXPERIENCES

In Norway and Scandinavia, gender equality is often considered a cornerstone of societal values, and significant progress has been made in various areas to promote women's rights and equal opportunities. However, gender bias in healthcare remains a persistent issue, and women's experiences with medical treatment continue to be influenced by societal attitudes, cultural norms, and systemic factors. This literature review focuses specifically on Norway and Scandinavia to explore the unique challenges faced by women in accessing healthcare, understanding their perceptions of medical treatment, and identifying potential areas for improvement in healthcare practices.

Even though the gender gap in Scandinavian countries is considerably smaller than in other countries, there are still some evident barriers that women find when attempting to access healthcare in the region. One of them pertains particularly to immigrant women and asylum seekers, however it also affects to a lesser degree Norwegian women is the lack of access to proper information. As Straiton & Myhre (2017) argue, learning to navigate a new healthcare system is a barrier when migrating. The authors found in their research a lack of information available in different languages, which directly affects those that are not fluent in Norwegian and makes their experiences in the healthcare system more difficult. There is also a need to rely on private networks in order to better understand how to navigate the healthcare system (Straiton & Myhre, 2017), which means that unless you personally know someone that is able to provide you with the information you need, there is a possibility that you will not be able to receive proper care, and this is something that affects everyone equally.

It is important to state that the healthcare model is different in different countries and therefore the assumption that migrants would understand the Norwegian model of fastlege gatekeeping is flawed and creates more barriers to access to services (Straiton & Myhre, 2017). When creating information about how to navigate the healthcare system, this must be taken into account and properly explained so that the users are aware of their duties and rights and how to go about the system to fulfill their needs.

In addition to this “power relations within healthcare are not necessarily visible to user groups who are new to a country and have little competence and scientific knowledge about the healthcare system” (Lien, 2017, p. 15). This means that immigrant people in Scandinavia that are not familiar with the way the healthcare system works and are not able to find proper information may be negatively affected by attempting to use the system based on previous experiences from other countries, yet another barrier to proper healthcare that is faced.

There are many difficulties that women still face in Scandinavia regarding receiving

proper healthcare treatment. As demonstrated above, some examples affect more directly immigrant women. In the rest of this section, other barriers that are faced by women in the region will be discussed.

Healthcare Disparities in Norway and Scandinavia

Despite Norway's reputation as a global leader in gender equality, studies have revealed persistent gender disparities in healthcare access and treatment. Research by Straiton & Myhre (2017) highlighted that woman in Norway experience longer waiting times for specialist consultations, with potentially detrimental effects on timely diagnosis and treatment. Another study that addresses this issue was conducted by Husby et al. (2003) and found that conditions that affect women, particularly endometriosis, tend to take a long time to be diagnosed.

Husby at al. (2003) debates that some of the reasons that cause this diagnosis to happen are the fact that the exam to discover the disease is high risk, the fact that some women experience improvements without interventions and that knowledge regarding having a chronic disease can affect women's psychological wellbeing. However, Husby et al. (2003) also argues that patients themselves attempt to advocate for their own diagnosis, which shows that they are aware of the risks, but prefer to go through them in order to be able to make properly informed decisions regarding their own health. What this contradiction raised by Husby et al. (2003) demonstrates is the fact that women need to be extremely assertive regarding their health in order to receive proper treatment. This fact shows that despite the region's forefront in gender equality, there is still many obstacles that women must face in order to be heard and seen as individuals capable of making decisions about their own lives.

Gender Bias in Medical Treatment

Gender bias in medical treatment is an issue that is not limited to any specific region but can manifest differently based on cultural and societal norms. In Norway and Scandinavia, as in other regions, studies have shown that women's symptoms are sometimes dismissed or attributed to psychological factors, leading to delayed or missed diagnoses (Husby et al., 2003)

This bias can be influenced by gender stereotypes, such as the perception of women being more emotionally expressive or prone to exaggeration when reporting symptoms (Samulowitz et al., 2018). Furthermore, the experience of gender bias in medical treatment can have profound psychological and emotional impacts on women. Research by Lisspers

et al. (2019) in Sweden found that women who experienced gender bias in healthcare reported higher levels of distress and feelings of not being taken seriously by healthcare professionals. These psychological effects can deter women from seeking medical care or speaking openly about concerns surrounding their health, potentially exacerbating these issues in the long term.

Intersectionality and Healthcare Experiences

An important aspect of understanding women's healthcare experiences in Norway and Scandinavia is considering intersectionality. Intersectionality refers to the interconnectedness of various socialcategories, such as gender, race, ethnicity, and socio-economic status, these ideas are reflected on the works of scholars such as Patricia Hills, where she often emphasizes the importance of reflexivity regarding the world and the changes that are constantly taking place, leading to a need for this to be reflected in academia in a broader spectrum. Women who belong to marginalized or disadvantaged groups may face compounded challenges in accessing quality healthcare. These ideas can be found in several of her books such as "Intersectionality" (Hill Collins & Bilge, 2020); "Black Feminist Thought" (Hill Collins, 1990); From Black Power to Hip Hop - Racism, Nationalism, and Feminism (Hill Collins, 2006); Intersectionality as Critical Social Theory (Hill Collins, 2019) & Fighting Words - Black Women and the Search for Justice (Hill Collins, 1998) to name a few of her works.

In Scandinavia, women who belong to marginalized or minority groups may face compounded challenges in accessing quality healthcare due to multiple layers of discrimination (Ahlin et al., 2018; Bains et al., 2021). For instance, immigrant women may encounter language barriers, encounter cultural norms that impact their healthcare-seeking behaviors or a lack of information regarding how to go about seeking proper medical care.

Moreover, intersectionality influences the experiences of indigenous women in the region. Research by Hansen (2015) in Norway highlighted the unique healthcare needs and challenges faced by indigenous Sámi women, particularly regarding cultural competence and sensitivity in healthcare provision. Such insights underscore the importance of considering intersectionality when addressing gender bias in healthcare to ensuremore inclusive and equitable healthcare practices.

Cultural Influences on Women's Health Behaviour

Cultural norms and practices can significantly impact women's health behavior

and attitudes towards seeking medical care in Scandinavia. In Sweden, research by Maltseva (2012) found that cultural norms around stoicism and self-reliance influenced women's willingness to seek help for mental health issues. Similar cultural norms may influence women's healthcare-seeking behaviors in other Scandinavian countries. The impact on women of these cultural norms is that they often delay seeking medical help and when they do, they often still need to deal with other delays due to different factors.

Additionally, cultural taboos surrounding reproductive health issues and other sensitive health topics can hinder open discussions and seeking appropriate medical care. In Norway, research by Dahlgren et al. (2018) highlighted that cultural norms around body image and disordered eating can affect women's perceptions of their own health and body concerns, potentially impacting their willingness to seek medical attention for eating disorders. This demonstrates that there are still many issues that women are discouraged to be open about due to fears of what the repercussions can be in the way society views them.

Promising initiatives and interventions in Scandinavia

Despite the challenges, there have been promising initiatives and interventions in Scandinavia aimed at addressing gender bias in healthcare and improving women's healthcare experiences. For instance, in Sweden, efforts have been made to provide culturally competent healthcare for immigrant women, recognizing the importance of tailoring healthcare services to meet the diverse needs of the population (Dellenborg et al., 2019). Given the influx of immigrants that Sweden and other Scandinavian countries received in the past few decades, these initiatives demonstrate that there has finally been a recognition that there have been problems and differences in treatment when it comes to the medical treatment of immigrants.

It is of note that cultural differences can have a heavy impact in health seeking behavior and expectations and therefore these initiatives are essential in order for the region to move forward and be able to provide a more well-rounded healthcare treatment to all of its inhabitants, regardless of their citizenship.

2.1.3 COMPARISON BETWEEN INTERNATIONAL AND SCANDINAVIAN EXPERIENCES

As it was demonstrated in the previous sections of this chapter, there are many

similarities when it comes to the difficulties faced by women all over the world. Despite Scandinavia being at the forefront of women equality movements, it is still possible to find gender bias in the region when it comes to healthcare treatment and how women's lives are affected by it. Furthermore, it was commonplace for women to have a higher burden of proof for their symptoms as well as a longer time in order to be properly heard and diagnosed, this is particularly significant when it comes to diseases that affect only women, such as endometriosis, demonstrating that worldwide there is still much to be learned and improved when it comes to women's health.

Another similarity that was found is the fact that there has been a recognisance worldwide of the need to improve training for medical personnel and that there are initiatives that are focusing on this issue. This is interesting as it has been found that one of the focuses of these trainings are in employing compassionate care in the treatment, demonstrating the importance of this theory in the medical field.

There are, however, some noteworthy differences as well, such as for example the fact that in Scandinavia women tend to be less subjected to patriarchal hierarchies as well as there is less expectations and taboos when it comes to their choices in healthcare. They are not exempt from it, but there is a significant smaller weight put on them than in other countries such as India, Zimbabwe, and Malawi. There is also a paradox in Scandinavia regarding women's health, as it seems that immigrant women are more subjected to those expectations and are less heard than Norwegian women. This creates a chasm in the way that women are treated in the region and it can lead to immigrant women having a worse perception of their healthcare treatment than those that were born in the countries.

A rich body of evidence shows that women's perception of healthcare treatment is a complex and multifaceted issue influenced by gender bias, societal inequalities, and cultural norms. The experiences of women with medical diagnosis and treatment can have far-reaching implications for their health and well-being. Addressing gender bias in healthcare is not only a matter of equity but also essential for ensuring optimal health outcomes for women worldwide. To create positive change, it is crucial to consider the impact of intersectionality on women's healthcare experiences, acknowledging the unique challenges faced by women from diverse backgrounds.

Promising interventions and initiatives can pave the way for a more inclusive and compassionate healthcare system that values and respects women's health concerns. By exploring international experiences, understanding the broader societal and cultural influences, and recognizing the efforts to address gender bias, we can work towards achieving gender

equality in healthcare. Empowering women to advocate for their health needs and promoting gender-sensitive healthcare practices are essential steps in improving women's healthcare experiences and overall well-being. Only through collective efforts can we create a healthcare system that ensures equal access to quality care for women, irrespective of their gender, race, ethnicity, or socio-economic status.

2.2 THEORETICAL LENSES

This thesis adopts a multidimensional theoretical framework to explore the research questions and shed light on the complex issue of gender bias in healthcare treatment experienced by women in Kristiansand, Norway. The three interconnected theories utilized in this study are the Theory of Compassionate Care with a specific focus on compassion as a human experience, Foucault's Theory of Power, and Gender Theory with a specific focus on gender stereotypes.

Firstly, this thesis will use the Theory of Compassionate Care to serve as the basis for the analysis, by providing a context of the way medical practitioners act towards their patients, which values are applied in the treatment and the communication that exists between the actors (medical personnel and patient, in the case of this study, women) and the way that those interactions are perceived. This means that this thesis will rely on looking at those interactions through a lens that values empathy and the impact that it has in medical care.

Secondly, this thesis will apply Foucault's theory of power in an attempt to shed light on the power dynamic that exists in the relationship between medical professionals and patients, particularly when it comes to the role that gender can affect this balance of power. This thesis will also utilize Foucault's concept of medicalization and the medical gaze, as it pertains directly to the way that women are treated within the healthcare system.

The last theory to be used will be Gender Theory, in which there will be a focus on the construction and perpetuation of gender stereotypes. This is important because the existence of these stereotypes often guide the relationships between men and women and can be the cause for many of the difficulties that women encounter in their medical care. Furthermore, it ties with the idea of balance of power in relationships raised by Foucault's theory, providing a well-rounded framework to analyse the findings of the research.

2.2.1 THEORY OF COMPASSIONATE CARE

The theory of Compassionate Care serves as a foundational framework for understanding the medical treatment provided to women and how it is perceived. Rooted

in the principles of empathy, sensitivity, and patient- centeredness, this theory emphasizes the importance of healthcare practitioners demonstrating compassion and understanding towards their patients (George, 2022). This is a key element of this research, given the fact that one of the obstacles faced by women in their healthcare treatment is the ability to been seen as capable individuals who are able to voice their concerns.

According to Nunberg & Newman (2000), compassion is described as "suffering with" or having a keen awareness of another person's suffering together with a desire to alleviate it. This description illustrates that there is a need for medical personnel to understand the patient in a more humane level and treat accordingly, and not only as impersonal subjects. While it is important to have a level of objectivity in medical treatment, it is also essential to treat the individual and this means looking at them as more than just a problem to be quickly solved and dismissed.

Even though the value of compassion is widely recognized across the healthcare field, it is critical to recognize that patients and their families attach great importance to the healthcare providers' qualities that are related to compassion (Fogarty et al., 1999; McDonagh et al., 2004; Riggs et al., 2014; Rodriguez et al., 2008; Roter et al., 1987; Sinclair et al., 2012), especially while nearing the end of one's life (Cherlin et al., 2004; Heyland et al., 2006). This shows us that as a general, people hope and expect that their medical personnel will show them a level of respect and empathy that can allow them to better process and go through the different situations that they are faced when dealing with medical treatments.

In addition, Heyland et al. (2010) and McDonagh et al. (2004), argue that patients and family members regularly perceive aspects of compassion as indications of excellent care, including receiving person-centered, responsive, and dialogic care. This means that when compassionate care is applied by medical personnel it can lead to a better relationship with patients and create a higher level of trust between them. It is possible to argue that trust is an essential part of the medical relationship, as both the doctors rely on the patients being open and truthful about their symptoms as well as the patients being able to trust that their doctors will have their best interest at heart and not judge them on the choices they make in their lives.

Patients, families, healthcare professionals, and policy makers acknowledge compassion as an essential component for excellent healthcare (Darzi, 2008). Because of global healthcare system changes, research on compassion in healthcare has acquired widespread interest. Which indicates that throughout the years it has been shown that the

impact of this type of treatment has been positive in the medical field and therefore it would be significant to have it applied more to treatment. Particularly in the case of women receiving medical care, compassion can play a fundamental role, as if the practitioners is able to understand and empathize with the different layers of difficulties that still face women today, they can be able to adjust their approach and even the type of treatment that is given to them.

Compassion, as a result of its 'human dimension,' is an important characteristic for patients, families, and healthcare providers to take into account as an essential component of high-quality healthcare (Aagard et al., 2018; Bloomfield & Pegram, 2015; Bramley & Matiti, 2014; Horsburgh & Ross, 2013; McCaffrey & McConnel, 2015; Schantz, 2007). There are several theoretical viewpoints on compassion and compassion aspects in healthcare in the literature. These include compassion as a set of attributes, compassion as a sequential cognitive, affective, and behavioral process, compassion as a response to suffering, compassion as a distinctive emotional state, compassion as a human experience, and compassion as both a state and a characteristic (George, 2022). For this study, the focus will be on the theoretical perspective of compassion as a human experience.

As a human experience, compassion is described as being fundamental in defining what it implies to be human being (Spandler & Stickley, 2020). This concept entails a deep and comprehensive sense of empathy for the suffering of others and a full and in-depth involvement with the human experience. This empathic understanding necessitates having direct experience with the suffering endured by others, triggering a moral obligation to respond to their distress and provide compassionate care (Peters, 2006). Compassion, according to some definitions, acknowledges a similarity with the distressed, recognizing that we may find ourselves in a comparable circumstance (Neff, 2003; Strauss et al., 2016).

Compassion has been linked to improved patient experiences and various patient-reported outcomes, including lower symptom burden (Fogarty et al., 1999; Sinclair et al., 2016; Vivino et al., 2009), improved life quality (Lown et al., 2017; Riggs et al., 2014; Sinclair et al., 2016; Soler-Gonzalez et al., 2017), and an improvement in ratings for the quality of care (Doohan & Saveman, 2015; McDonagh et al., 2004; Sinclair et al., 2016), this demonstrates that there is a substantial basis to employ this type of care when treating patients. Compassion is not only a basic human value, but it should also be considered an essential part of the medical field.

Although compassion is acknowledged as a care standard and an essential aspect of patients' healthcare experiences, it has additionally been shown to be in inadequate

provision (Brown et al., 2013; Crowther et al., 2013; Heyland et al., 2006; Lown et al., 2011; McDonagh et al., 2004; Sinclair et al., 2016). The NHS Commissioning Board (2012) and Paterson (2011) both note that the provision of compassion needs significant improvement. There are many factors that could explain this deficit, such as the commercialization of medicine and the level of objectivity that medical personnel are taught in their education. Compassion deficit has been linked to higher rates of patient and family grievances, escalated healthcare expenses, and a rise in adverse medical incidents (Attree, 2001; Lown et al., 2011; West et al., 2006).

As a result, because compassion is a fundamental human experience in healthcare that plays a critical role in improving patient outcomes, fostering trust, and promoting overall well-being, the Theory of Compassionate Care will be applied in this study to investigate how the presence or absence of compassionate care influences women's experiences in healthcare settings. As discussed in the previous chapter, the existence of this type of treatment has been taken seriously both in Scandinavia and worldwide, with several initiatives aimed at increasing medical training when it comes to their levels of sensitivity treating patients. This shows us that the employment of compassionate care can pave the way to improving conditions and perceptions when it comes to patients' healthcare experiences.

By examining women's perceptions of their interactions with healthcare providers, this theory will help identify whether compassionate care contributes to a sense of being heard, valued, and respected. Additionally, this thesis will explore the impact of compassionate care on women's willingness to seek medical attention promptly and how it affects their overall quality of life.

2.2.2 FOUCAULT'S THEORY OF POWER

The theory of compassionate care can be connected to Foucault's power theory by examining how compassion is embedded within the dynamics of power relations in healthcare and broader societal contexts. Foucault's work emphasized the pervasive influence of power structures in shaping our behaviors and perceptions. In the context of healthcare, the power dynamics between healthcare providers and patients are evident. Compassionate care can be seen as a response to these power imbalances, as it aims to reduce the asymmetry between healthcare professionals and patients, fostering a more egalitarian relationship. Compassion, in this context, can be a means of resisting and humanizing the often-dehumanizing effects of institutionalized power.

In healthcare, compassionate care can be seen as a tool to manage and govern the health and well-being of individuals. The practice of compassionate care can be influenced by societal norms and expectations, which are constructed and reinforced through power structures. By recognizing the connection between compassionate care and Foucault's power theory, it is possible to better understand the complex interplay between care, power, and the way individuals are governed within healthcare systems and society at large.

Michel Foucault's theory of power offers a critical perspective for examining the dynamics between power and societal structures. This lens proves invaluable in understanding gender bias within healthcare and how individuals have access and receive treatment. Foucault (1979) challenges the notion that authorities solely wield power in a top-down manner. Instead, he emphasizes its pervasive presence throughout society within various institutions, practices, and discourses. He goes on to discuss the importance of the fact that there are different ways in which power relationships are established and impact people’s lives.

Within the realm of healthcare, power operates in intricate ways that shape the delivery, access, and overall healthcare experience. Foucault's concepts provide insightful information when investigating gender bias in healthcare. His description of pastoral power is of great value to understanding the way power relationships play out in the medical field. It can be said that pastoral power is based on the idea that individuals accept the existence of an external power that created norms with their best interests at heart and follow the rules set by this power (Bevir, 1999). While Foucault’s original theory is based on a religious concept, it has evolved in secular society to affect what individuals follow in regard to their health and well-being (Bevir, 1999). This demonstrates that there is an inherent willingness from patients to believe and follow guidelines set by those they perceive as their medical caretakers, as they believe that their well-being is being prioritized.

The concept of "biopower” is also ascribed to Foucault’s theory of power. This concept describes the exercise of control and regulation over people's bodies and general well-being (Foucault, 1979). This concept has been used in a variety of contexts, going beyond physical health to include issues such as risk management, heredity regulation, and public health initiatives. This can be further exemplified by gender bias, which reveals that some healthcare practices and policies may disproportionately affect particular gender groups, resulting in uneven access to treatment or the priority of some health issues over

others (Hancock, 2018). However, the affected individuals may believe that they have autonomy in the decision-making process, as gender bias is not always easy to spot.

Pastoral power relies on the use of discipline by individuals to employ a negative form of power (Bevir, 1999) and therefore there is no openly top-down power relationship. It gives individuals an illusion of control and of the status of their power in a relationship. As Foucalt (1977) argues, there is a high level of complexity when it comes to the relationship that exists between doctors and patients and this provides ample opportunity for a power balance to be either oppressive or productive, depending on the way that both approach the situation.

This thesis argues that researchers may better comprehend how power structures affect health systems, medical knowledge, and patient experiences by analyzing bias against women through a Foucauldian lens. This viewpoint encourages the promotion of more inclusive, equitable, and patient-centered healthcare services while making it easier to identify and challenge underlying beliefs and behaviors that sustain disparities. It also challenges healthcare professionals to critically assess their biases and take into account social, cultural, and gendered issues that affect health outcomes.

The power/knowledge nexus is the first notion in Foucault's theory of power. This concept embodies Foucault's radical theory that knowledge systems and power actions are mutually constitutive and "directly imply one another" (Foucault, 1979, p. 27). Medical knowledge and expertise frequently perpetuate gender stereotypes, influencing how specific illnesses or experiences are viewed and treated. Gender stereotypes can contribute to inequities in healthcare, where particular symptoms or concerns may be disregarded or discounted (Pylypa, 1988). Furthermore, women often have their voices omitted as they are not perceived as holders of knowledge (Young et al., 2019). This dismissal of their experiences due to a concept that they are not capable of having the same knowledge as men shows the level of power relations and gender bias that exist.

Another concept from Foucault's theory of power is “discourse.” The term "discourse," as established by Foucault (1979), alludes to the linguistic and representational systems that influence how we comprehend the world. Certain gendered discourses in the healthcare industry may be responsible for bias, stigmatization, and poor treatment of some health concerns, particularly those stigmatized as "taboo" or connected to reproductive health (Pylypa, 1988). Additionally, discrepancies in healthcare services are a result of the marginalization of women's health issues and concerns (Vlassoff, 2007). A barrier to women’s having adequate access and thorough care may be the prevalent

medical discourse, which may prioritize some elements of women's health while ignoring others.

Foucault also proposed the concept of the "medical gaze," detailing how clinicians exclude information that they judge unimportant in order to fit a patient's story into a biomedical framework (Foucault, 1979). As a result, healthcare professionals have a tendency to objectify patients and simplify people to their illnesses. According to Foucault, the medical gaze maintains hierarchical connections between the medical professional and the patient instead of being solely a neutral, objective observer. The quality of treatment may be impacted by the gendered components of this gaze since specific issues can be disregarded or ignored due to stereotypes regarding gender (Hancock, 2018).

An evolution of this concept is the creation of the medical case, which has been employed in medical education since the 1960's (Tierney, 2004). This concept is highly controversial as it reduces the individuals to what the medical practitioner chooses to report on their case and what they value as important, which does not always match everything that the patient describes (Tierney, 2004). This is another instance in which power comes into play in the doctor-patient relationship and shows the imbalances as it remains at the doctor's description what to take into account.

Furthermore, Foucault developed the concept of "medicalization." The process through which human experiences and circumstances that were formerly thought to be normal or outside the purview of medicine are changed into medical problems is known as medicalization (Foucault, 1979). By examining the historical growth of medical knowledge and authority, Foucault highlighted how society's perception of health and sickness has evolved through time. According to Foucault, social and cultural aspects in addition to scientific advances in medicine affect medicalization. Because healthcare organizations and healthcare providers may impose influence over people's bodies and experiences, he thought that medicalization constituted a kind of social control.

Power structures have the ability to pathologize and control several facets of life for humans by categorizing certain actions or circumstances as medical conditions (Foucault, 1979). The medicalization of women's bodies is illustrative of how Foucault emphasized how institutions and cultural norms manage bodies. For example, medical authorities have historically exercised control over and regulation over women's reproductive health (Hancock, 2018). The experience of women seeking medical treatment may be impacted by the overuse of medicine or the disregard of their concerns because of this medicalization.

In addition, Foucault's theory of power included the concept of "institutional power". Institutions and structures influence people's experiences in many ways (Foucault, 1979). Gender bias may manifest itself in healthcare settings as uneven treatment, dismissive attitudes, and restricted access to specialist care for particular genders (Pylypa, 1988). Institutional biases and gender inequities can limit women's access to effective care, prompt diagnoses, and treatment options in some healthcare systems. Socioeconomic issues may additionally influence how differently women, particularly those from marginalized backgrounds, perceive healthcare.

Finally, understanding "resistance" is essential for comprehending how society's power structures work as well as how people may confront and overcome them. Humans can oppose and confront such dynamics despite the repressive power structures (Foucault, 1979). To meet their unique needs for healthcare, this can entail looking for alternative healthcare practices, promoting gender-centered treatment, or creating support networks (Hancock, 2018).

In the context of this study, this theory helps understand the ways in which power operates within healthcare systems and how it influences the dynamics between healthcare providers and women seeking medical care. Foucault's concepts of medicalization and the medical gaze will be particularly relevant to explore how medical institutions and professionals exert power over women's bodies and health decisions. By examining the subtle mechanisms of power within the healthcare system, this theory will contribute to uncovering potential disparities and biases in medical treatment experienced by women. It will also shed light on how societal norms and expectations related to gender can influence healthcare practices, further perpetuating gender bias in medical treatment.

2.2.3 GENDER THEORY WITH A FOCUS ON GENDER STEREOTYPES

Furthermore, Foucault's theory of power can be intricately linked to gender theory, especially when examining the pervasive issue of gender stereotyping. Foucault's ideas on the ways in which power is exercised through discourse and knowledge production are particularly relevant in the context of how gender stereotypes are constructed and perpetuated.

Gender stereotypes are a product of social norms and expectations, shaped by those in positions of power and disseminated through various institutions, such as media, education, and culture. These stereotypes reinforce the binary notions of masculinity and femininity, which are deeply embedded in power structures. In essence, Foucault's notion of

power as productive and discursive illuminates how gender stereotypes are actively created, disseminated, and maintained by those in power to control and regulate individuals based on their perceived gender identities.

Furthermore, the enforcement of gender norms and expectations can be seen as a form of discipline, where individuals are subjected to societal regulations that maintain the gender binary. Those who deviate from these norms are often subjected to various forms of social control, including stigmatization and discrimination. Gender theory, when viewed through the lens of Foucault's power theory, highlights the inherent mechanisms of power at play in the creation and enforcement of gender stereotypes, revealing the ways in which these stereotypes are used to maintain traditional power structures and the dominance of certain gender identities over others.

Gender Theory, with a specific focus on gender stereotypes, offers valuable insights into the construction and perpetuation of societal norms related to gender roles and behaviors. Gender theory emerged during the 1970s and 1980s as a collection of concepts that guided historical and other Western studies (Jule, 2014). Fundamentally, the theory recommended viewing masculinity and femininity as distinct sets of mutually produced attributes that shape men's and women's lives (Jule, 2014). This creation of specific roles assigned to each gender has created the way that societies are organized and what is expected behavior of each person according to their gender. In a way, it is possible to argue that it created a cage in which people are fitted into at birth and that pre-determines several aspects of their lives.

Foucault (1980) contends that when people are taught to practice self-surveillance and self-discipline "voluntarily," power relations in daily life are ingrained in disciplinary institutions like educational institutions, jails, and healthcare facilities. Humans internalize social norms, such as gender stereotypes, and behave in accordance with them. This notion is consistent with the social constructionism theoretical perspective (Berger & Luckmann, 1967), which contends humans adapt to social notions of femininity and masculinity in order to behave in particular ways (Courtenay, 2000).

Instead of being only passive recipients of socially created gendered roles, these individuals actively participate in co-producing such roles and perceptions (Courtenay, 1998). In this regard, the "doing of health" is a form of "doing gender," according to Saltonstall's (1993) assertion that "health actions are social acts" (p. 12). This means that everyday actions help increase the perception of how people believe themselves to be and how they believe others view them based on their gender. There has been much in recent

years to attempt and break with gender roles and stereotypes, however much of it is ingrained in society and reversing them will take a long time.

Males and females internalize gender stereotypes in various ways. Some research has found that conventional views about manhood and masculinity are important determinants of health behaviors and adverse health outcomes, leading males to suffer greater social pressure and internalize the stereotype characteristics of gender groups than females (Courtenay, 2000; Ng et al., 2007). Other researchers, for example, Pavlova et al. (2014) found that gender stereotypes have a greater impact on females. This contraction shows us that everyone is differently and negatively affected by these stereotypes and expectations. While males tend to suffer more social pressure, the results that females incur in their lives due to gender stereotypes can be more significant.

Gender also influences the expression of illness symptoms, mobilization of social support, and the socio-cultural ethos that influences access to proper treatment and care. Gender variations in symptom experience and expression suggest that females desire more social assistance than males and experience a significantly higher level of distress (Kawachi & Berkman, 2001; Tenenbaum et al., 2017). The cultural norms that are prevalent among specific societies may be somewhat responsible for this phenomenon.

While masculine roles often emphasize independence and placing family obligations ahead of community needs, interactions with others and exhibiting communal behavior are frequently connected with feminine roles in other cultures (Carli, 2001). Contrarily, according to Macintyre et al. (1993), men are more inclined than women to report and seek treatment for problems related to the common cold. It is also important to note that males and females can present vastly different symptoms for the same disease and that there is less research into females' symptoms, usually with the males being taken as the standard for symptoms for a disease (Walsh, 2019).

Gender relations are also likely to cause other cultural barriers to women's access to healthcare. Vlassof (1994) states that women's inferior standing within the family and society has a substantial impact on their capacity to access crucial services including healthcare, decision-making opportunities, education, and economic resources. Consequently, women remain misinformed about health concerns, fail to recognize sickness, and must rely on older family members or men for healthcare. The lack of access to knowledge is highly influential in women's ability to advocate for themselves, as they are not equipped with the means to do so. This phenomenon is especially evident in countries where such institutional restraints prevent women from paying attention to or seeking

medical care for their illnesses (Malhotra et al., 1995).

Finally, gender differences may affect the actual healthcare access, which includes treatment. Although women are more likely to recognize and seek treatment for illnesses, they frequently face barriers to care for problems with social ramifications. In a study that included both Caucasian males and females, it was discovered that women seeking help for alcoholism face more substantial social obstacles than men (Beckman & Amaro, 1986). Once more demonstrating the level of symptom burden that women must present is higher than of their counterparts. Furthermore, women seeking general healthcare are more likely to face resistance and social ramifications from their family and friends, a situation rarely encountered by men in comparable situations.

As a result, socially constructed gender stereotypes have varied effects on individual health, and gender and health-seeking behavior can be related both directly and indirectly. Based on the social and cultural context, the manner in which gender impacts health-seeking and access to health can have beneficial and harmful consequences for either gender. By examining the impact of gender stereotypes on women's lives, this theory will illuminate how internalized concepts and societal expectations can shape women's perceptions of their healthcare needs and influence their interactions with healthcare providers. The theory will explore how gender stereotypes may lead to the dismissal or trivialization of women's symptoms, hindering their access to appropriate medical care. Furthermore, it will investigate the role of gender stereotypes in shaping women's reporting behaviors concerning symptoms and seeking timely medical attention.

Overall, by combining these three theoretical perspectives, this study seeks to provide comprehensive and nuanced understanding of the possible existence of gender bias in healthcare treatment for women in Kristiansand. The theoretical framework will help analyze the complexities and interplay of compassionate care, power dynamics, and gender stereotypes in shaping women's experiences and perceptions of their medical care. Through this multidimensional approach, the research aims to contribute to the advancement of women's healthcare by identifying potential areas for improvement and advocating for a more equitable and patient-centered healthcare system.

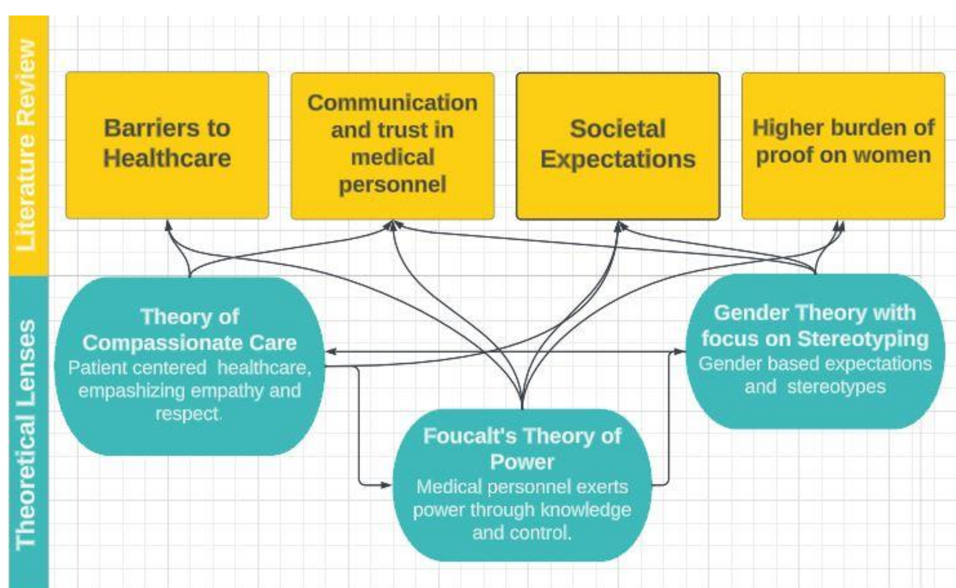
2.3 THEORETICAL FRAMEWORK

The interplay between the theories of Compassionate Care, Foucault's Power Theory, and Gender Theory reveals a complex web of power dynamics, social norms, and care practices. Compassionate care can be seen as a response to the power imbalances within

healthcare, striving to humanize the patient-provider relationship and counter the dehumanizing effects of institutionalized power. Within this context, Foucault's power theory underscores how power shapes healthcare practices, and compassionate care can be viewed as a means of resistance against power structures that often control healthcare decisions. When we consider the intersection of gender theory, it becomes apparent that gender stereotypes, constructed and perpetuated through power structures, significantly influence the experience of compassionate care, as individuals may encounter gender-based bias and discrimination within healthcare. These theories collectively illustrate the intricate ways in which power, compassion, and gender stereotypes intersect and impact our understanding of care practices in healthcare and society.

In addition to these theories, as discussed in previous sections, women's experiences with the healthcare systems are very multifaceted. As shown, both in Scandinavia and the rest of the world, it is still possible to find gender bias in women's treatment by medical personnel. Their experiences are also affected by the imbalance of power to which they are subjected which often makes be less heard by doctors. This is in line with the gender stereotype that women are more dramatic, causing them to have to go through more difficulties to prove that they are in fact in need of medical assistance. Furthermore, the literature review also revealed that there is a need to improve training for medical personnel, particularly when it comes to how to address patients with a more empathetic perspective.

The diagram below helps to illustrate the interplay between the theoretical lenses and the literature review:



3. METHODOLOGY

The choice of a qualitative research design for this study stems from its ability to delve deeply into the lived experiences and perceptions of women regarding their medical care. Qualitative research is well-suited to explore complex social phenomena, providing a holistic understanding of the multifaceted nature of gender bias in healthcare (Pyo et al., 2023). By adopting this approach, the study aims to uncover the nuanced aspects of women's encounters with the healthcare system, shedding light on their unique perspectives, motivations, and emotions.

Semi-structured interviews were selected as the primary data collection method due to their flexibility and ability to yield rich and meaningful data (DeJonckheere & Vaughn, 2019). These interviews strike a balance between structure and openness, allowing the researcher to have a predefined set of questions while also providing space to explore unanticipated themes that emerge during the conversation. Through this approach, participants can freely express their thoughts and feelings, unencumbered by rigid survey formats, ensuring that their voices are authentically captured. The open-ended nature of the interviews fosters trust and rapport, enabling the researcher to create a safe and empathetic environment where participants feel comfortable sharing their experiences of gender bias in healthcare.

The rationale behind choosing Kristiansand, Norway, as the study location lies in its unique demographic composition and accessibility. Being a medium-sized city, Kristiansand offers an ideal setting to examine gender bias in healthcare, as it provides a diverse mix of Norwegian- born residents and immigrants from various cultural backgrounds. This diversity enriches the study's findings, as it allows for the exploration of potential variations in healthcare experiences among different groups of women.

Additionally, Norway's reputation for its progressive healthcare system and commitment to gender equality makes it a compelling context to investigate the persistence of gender bias despite advancements in healthcare policies. By situating the study in Kristiansand, the research can benefit from the interplay of cultural diversity and Norway's healthcare ethos, contributing to a more nuanced understanding of gender bias in healthcare.

3.1 SELECTION OF PARTICIPANTS

To ensure the study's relevance, accuracy, and representativeness, a purposive sampling technique was employed for participant selection. This deliberate approach allows the researcher to handpick participants who possess the specific characteristics essential for addressing the research questions comprehensively.

The criteria used for selecting participants was:

- Participants must identify as women and be 18 years of age or older, ensuring that the study focuses on the experiences of adult women who have navigated the healthcare system.
- Participants should have resided in Kristiansand for at least three years, ensuring that their experiences are rooted in a meaningful connection to the city's healthcare facilities and services.
- Participants must possess fluent or advanced English language skills, as interviews will be conducted in English to facilitate communication and maintain consistency in the data collection process.

The deliberate selection of participants from both Norwegian-born and immigrant backgrounds is a critical aspect of the study's design. By including women from diverse cultural backgrounds, the research aims to capture a comprehensive range of perspectives on gender bias in healthcare, acknowledging potential variations in experiences based on cultural norms, beliefs, and communication styles.

To recruit participants, the researcher adopted a multifaceted approach. Firstly, leveraging personal connections and referrals was instrumental in identifying and approaching women who meet the specified criteria. Secondly, collaboration with the Facebook group "Kristiansand Internationals" served as a gateway to reaching immigrant women interested in contributing their experiences to the study. This two-prong approach allowed the researcher to reach the interviewees and find a quantity of women willing to discuss their experience that was enough for the study. These strategies were aimed to ensure a diverse and comprehensive participant pool, enriching the study's data with a multiplicity of viewpoints.

To uphold ethical principles, potential participants received an information sheet outlining the study's purpose, objectives, and the voluntary nature of their participation. The sheet also detailed confidentiality measures and the participants' right to withdraw from the study at any stage without consequences. Obtaining informed consent through a consent form was an integral part of the process, underscoring the researcher's commitment to ensuring participants' autonomy and protection throughout the study.

By employing purposive sampling and carefully considering the participants' backgrounds, this study endeavours to capture a multifaceted and authentic portrayal of women's experiences with gender bias in healthcare, thereby contributing to the advancement of equitable and compassionate healthcare practices.

3.2 FEMINISM AND QUALITATIVE RESEARCH

Feminist scholars have long argued that traditional quantitative research methods may not adequately capture the complexities of gender-related issues and women’s experiences. This perspective is echoed by Bryman (2016), who highlights two key factors that make qualitative research particularly well-suited for feminist studies. Firstly, there is a prevailing view that quantitative research, with its emphasis on numerical data and statistical analysis, may not fully align with the nuanced and multifaceted nature of feminist inquiry. Quantitative methods often prioritize objectivity and generalizability, which may inadvertently overlook the unique and diverse experiences of women in various contexts.

In contrast, qualitative research offers a more interpretive and context-specific approach, allowing researchers to delve into the lived experiences, voices, and subjectivities of women (Pyo et al., 2023). By focusing on in-depth exploration and understanding, qualitative methods provide an opportunity for researchers to engage in empathetic listening and narrative analysis, which can give voice to marginalized perspectives and highlight the nuances of gender bias in healthcare. This aligns with the feminist goal of centring women’s experiences and challenging the dominant narratives that may perpetuate gender inequalities.

Secondly, qualitative research allows for a feminist sensitivity to come to the fore during the research process (Freeman, 2019). There is also a need to highlight the importance of reflexivity, acknowledging the researcher’s role in shaping the research and recognizing the potential biases that may influence the interpretation of data. Qualitative methods provide researchers with the space to reflect on their own positionality and its impact on the study, leading to a more transparent and ethical approach to research.

In the context of this study, which heavily focuses on gender bias in healthcare, the alignment with feminist principles further reinforces the choice of qualitative research. By adopting qualitative methods, the research seeks to understand the unique experiences and challenges faced by women in accessing healthcare, without reducing their narratives to mere statistical data points. This approach recognizes the importance of women’s voices and perspectives, which are central to understanding the complexities of gender bias in the healthcare system.

Moreover, qualitative research allows for the exploration of the broader social and cultural contexts in which gender bias operates. It enables researchers to investigate the influence of societal norms, cultural beliefs, and power structures on women’s healthcare experiences. By acknowledging and engaging with these contextual factors, the study can

contribute to a more comprehensive and nuanced understanding of the systemic challenges that perpetuate gender bias in healthcare settings.

In summary, the adoption of qualitative research in this study aligns with feminist principles by providing a more empathetic and context-sensitive approach to understanding gender bias in healthcare. By amplifying women's voices and perspectives, qualitative methods facilitate a deeper exploration of the complexities surrounding this issue. Moreover, qualitative research empowers researchers to be reflexive and aware of their own biases, contributing to a more ethical and transparent investigation. Through this feminist-informed lens, the study aims to contribute meaningfully to the discourse on gender equity in healthcare and advocate for more inclusive and compassionate healthcare practices for all individuals, regardless of gender.

3.3 LEVELS OF SAMPLING

3.3.1 SAMPLING OF CONTEXT

The sampling of context involves selecting the area or setting in which the study will take place to contextualize the research findings. In this study, the focus was on the city of Kristiansand in Norway. Kristiansand's selection is based on several factors that make it an ideal location for investigating gender bias in healthcare. As a medium-sized city, Kristiansand offers a diverse demographic composition, encompassing both Norwegian-born residents and immigrants from various cultural backgrounds. This diversity is crucial for capturing a wide range of perspectives on healthcare experiences and gender bias. Additionally, Kristiansand's accessibility and manageable size provide an opportunity to engage with a sufficient number of participants while ensuring meaningful and in-depth interactions during data collection. Given the scope of the study, the comparison with other areas will not be pursued, as the primary focus is on understanding gender bias in healthcare experiences within the specific context of Kristiansand.

3.3.2 SAMPLING OF PARTICIPANTS

The sampling of participants was designed to ensure that the study contained a quantity of individuals from the population of interest that reached the point of saturation, meaning that new insights and information to respond to the research questions were no longer provided by adding new participants as well as a point was reached where enough depth to the study was achieve with different nuances provided by the different participants. In this study, the goal is to recruit women who reflect the diverse population of Kristiansand, with participants encompassing both Norwegian-born women and immigrant women. By including participants

from different backgrounds, the study seeks to capture the unique experiences and perspectives related to gender bias in healthcare across cultural and social contexts.

3.3.3 SAMPLE SIZE

Determining the appropriate sample size for a qualitative study can be challenging, particularly when based on interviews and comparisons. In this study, the sample size determined was 16, evenly distributed between Norwegian-born and immigrant women, this was the point that the study reached saturation as mentioned previously The decision to keep a relatively smaller sample size aligns with Crouch and Mackenzie's (2006) notion that smaller samples can provide more in-depth data, facilitating a thorough exploration of participants' experiences and perceptions. By conducting in-depth interviews with a smaller group of participants, the study aimed to generate rich and meaningful insights into the complexities of gender bias in healthcare.

While a larger sample size could potentially yield more diverse perspectives, the nature and time constraints of this study necessitated a manageable sample that still allows for a comprehensive examination of the research questions. However, it is acknowledged that the sample size may be considered a limitation of the study, and this will be transparently discussed in the research report.

To justify the selected sample size, several key considerations outlined by Bryman (2016) were considered. These included:

Saturation: The point at which new information and themes cease to emerge from the data will be monitored to ensure that the sample size is sufficient to reach data saturation.

Minimum requirements for an adequate sample: The study's focus on gender bias in healthcare experiences requires a sample size that adequately captures the nuances and variations in participants' perspectives.

Style of the research: The qualitative nature of the study, centred on in-depth interviews, supports a smaller sample size to facilitate deeper exploration.

Heterogeneity of the population and research questions: By including both Norwegian-born and immigrant women, the study seeks to encompass diverse experiences and perspectives, addressing the research questions comprehensively.

3.4 LANGUAGE OF INTERVIEWS

To streamline the data collection process and enhance communication, all interviews were conducted in English. This decision was made to avoid the need for translators and

maintain consistency in the language used during the interviews. By conducting interviews in a common language, the study seeks to facilitate a smoother and more efficient data collection process. While conducting interviews in English may limit the pool of potential participants who are fluent or have advanced English language skills, it also offers several advantages. Firstly, the absence of a translator fosters direct and unfiltered communication between the researcher and participants, reducing the risk of misinterpretations or nuances being lost in translation.

Secondly, the use of a single language allows for easier comparison and analysis of the data, as there will be no language barriers to contend with during the data analysis phase. It is acknowledged that using English as the sole language of interviews may restrict the diversity of participants, especially among those who are not as fluent in English. However, the decision to conduct interviews in English was made to strike a balance between practical considerations and the desire for clear and unobstructed communication during data collection.

3.5 TRANSCRIPTION OF INTERVIEWS

To ensure a robust and thorough analysis, all interviews were transcribed after they have taken place. Transcription involves converting spoken words from the interviews into written text, facilitating a detailed examination of participants' responses and experiences. In order to perform this task, the research employed the use of the AI software available at Universitet i Oslo that complies with GDPR rules and is available to students in Norway.

Firstly, transcribing interviews allows the researcher to immerse themselves in the data and gain a deeper understanding of the participants' narratives. While the transcriptions are done through a software, the researcher afterwards went through all of it comparing with the audio to ensure that discrepancies were addressed and corrected. This provided the researcher with a more in-depth understanding of the data and facilitated the analysis process.

Secondly, to ensure the confidentiality and anonymity of participants, all personal information was anonymized during transcription. Participants in the study are referred to as "Norwegian" or "Immigrant," followed by a unique identifier (e.g., Norwegian 1, Norwegian 2, Immigrant 1, Immigrant 2). Anonymization is a critical aspect of ethical research practices, protecting the privacy and confidentiality of participants and their data.

By investing in the transcription process, this study aims to conduct a comprehensive and rigorous analysis that does justice to the richness of participants' narratives and perspectives.

3.6 TYPE OF ANALYSIS

Thematic analysis is a qualitative method that focuses on identifying and analysing themes or patterns of meaning within the data. It involves a detailed and systematic examination of the data to identify commonalities, differences, and underlying concepts. Thematic analysis is inductive, meaning that themes emerge directly from the data rather than being preconceived (Vaismoradi et al., 2013). Researchers code and analyse the data to identify recurring themes, which are then grouped together to form a comprehensive understanding of the subject under study. Thematic analysis provides rich insights into participants' perspectives, experiences, and emotions, allowing for a deeper exploration of the research questions.

The thematic analysis for this study focused on systematically examining the data obtained from the semi-structured interviews. Thematic analysis is a widely used qualitative method that allows the researcher to identify, analyse, and report patterns or themes within the data. In this study, thematic analysis was used to gain a deeper understanding of women's experiences and perceptions of gender bias in healthcare treatment. The data analysis was conducted using a dual approach, applying both inductive and deductive methods. This combination aims to provide more depth to the analysis, since inductive involves allowing the researcher to identify patterns that emerge from the data while deductive starts with theories and applies them to the specific case to draw conclusions. This approach can provide a more comprehensive understanding of the nuances of the subject of women's perceptions of health, while still ensuring that the analysis is coherent.

The deductive themes were:

1. Ability to trust doctor: This theme explores women's experiences and perceptions of trust in their healthcare providers. It delved into the factors that influence their level of trust, such as communication, empathy, and respect from healthcare professionals.
2. Perception of external factors in medical care (Background, economic situation): This theme focused on how external factors, such as cultural background and economic situation, influence women's medical care experiences. It explored whether women from different cultural backgrounds or economic situations perceive differences in the treatment they receive and if these perceptions contribute to disparities in healthcare experiences.
3. Impact of stereotypes when seeking medical care: This theme delves into the influence of gender stereotypes on women's interactions with healthcare providers and the medical system. It examined how gender stereotypes may lead to the trivialization or dismissal of

women's symptoms, affecting their access to appropriate medical care and how women navigate these challenges when seeking medical attention.

4. Knowledge of healthcare system: This theme explored the impact that knowing the healthcare system can have on women's ability to seek proper medical care. It examined if there were any discrepancies between Norwegian and immigrant women and how each of the groups interact with the healthcare system.

The inductive themes were:

1. Ability to communicate in Norwegian:
2. Difficulty in getting a consult with a doctor or specialist: This theme discusses the impact that this barrier is for women when using the healthcare system. It examined the way that women felt about this difficulty and the consequences it had for them.
3. Change in Behaviour by Immigrant women: This theme explores the way that immigrant women's relationship to the healthcare system changed overtime. It analyses how they behaviour was affected by the system and the impacts it had on them.
4. Lack of preventive medicine: This theme will explore the implications that the Norwegian approach to health has on women's perception of it. It will examine how women feel about this situation and how it affects their life.

3.7 DATA COLLECTION

The data collection procedure for this study involved conducting semi-structured interviews with the selected participants. Semi-structured interviews offer a balance between providing a set of predefined questions to guide the conversation and allowing for flexibility to explore unexpected avenues of inquiry. This approach allows participants to share their experiences, perceptions, and emotions related to gender bias in healthcare openly and in their own words, providing rich and valuable data. Before the interviews take place, each potential participant will receive an information sheet detailing the study's purpose, objectives, confidentiality measures, voluntary participation, and their right to withdraw at any time without consequences. This informed consent process is crucial for ensuring that participants fully understand the study's nature and their role in it, as well as protecting their rights and privacy.

Participants were also given sufficient time to review the interview questions provided in advance, which served as a guide for the interviews. The interviews were all conducted in in-person based on the participants' preferences and practical considerations. In-person interviews foster a more personal and intimate atmosphere.

In order to maintain consistency and rigor in data collection, a semi-structured interview guide was used for each interview. The guide included open-ended questions that align with the research questions and thematic areas identified for analysis. The interview guide was flexible enough to accommodate diverse responses while ensuring that relevant topics related to gender bias in healthcare were explored. This approach allowed the researcher to delve deeper into participants' experiences and follow up on interesting or unexpected insights that emerged during the interviews.

During the interviews, the researcher did its best to create a supportive and non-judgmental environment to encourage participants to express their thoughts and experiences freely. Active listening and empathetic communication were employed to establish rapport and trust, enabling participants to share their experiences openly and honestly. The duration of each interview was quite varied and depended on the depth of the participants' responses and the range of topics discussed. On average, interviews lasted approximately 25 to 35 minutes, with some being slightly shorter and some being slightly longer. All interviews were audio-recorded, with the participants' consent, to ensure accurate capture and preservation of the data.

After data collection was completed, the audio recordings were then transcribed using the software available at Universitet i Oslo that complies with GDPR rules, as mentioned earlier, to create a written record of the interviews. Throughout the data collection process, field notes were also taken by the researcher to document any observations, reflections, or insights that the audio record was not able to provide. Field notes contributed to the reflexivity of the study, allowing the researcher to reflect on their role and potential biases that may have influenced the data collection process.

To enhance the trustworthiness and rigor of the study, member checking was then employed. Member checking involved sharing a summary of the interviews with the participants to ensure accuracy and gain their feedback on the representation of their experiences. This process promoted participant validation and enhanced the study's credibility.

In summary, the data collection procedure for this study involved semi-structured interviews with selected participants, conducted in-person. The use of an interview guide to facilitate consistency and focus during the interviews was employed, and the audio recordings and transcription process helped ensure accurate data capture. Field notes and member checking further contributed to the study's rigor and trustworthiness. Through these comprehensive data collection efforts, this research aims to provide meaningful insights into women's experiences and perceptions of gender bias in healthcare in the city of Kristiansand, Norway.

4. FINDINGS AND ANALYSIS

In this chapter, the researcher will present the findings and analysis surrounding this thesis. By choosing to combine these two parts into one chapter, the researcher hopes to provide a more concise and in-depth presentation of the research and its subsequent analysis. This can allow the researcher to delve into the topics raised during the research and right after demonstrating how it ties with the rest of the thesis. The main objectives of this chapter are:

- To present the collected data in a clear and concise manner, providing a comprehensive overview of the research findings;
- To analyze the data systematically, drawing connections to the research questions;
- To identify patterns and trends within the data;
- To discuss the implications of the findings in the context of existing literature, offering insights that contribute to the field of study;
- To assess the limitations of the research and discuss their potential impact on the validity and generalizability of the findings.

This chapter will build upon the previous ones and the intent is to be able to answer the research questions of this thesis, while using the literature review and theoretical framework as a basis for the analysis. In this thesis, the research questions that were set out to answer were:

1. To what extent does women's perception of their medical treatment affect their quality of life?
2. To what extent do women in Kristiansand believe the medical treatment they receive is adequate to their needs?
3. Is there any difference in the perception of treatment between immigrant women and Norwegian born women?
4. Is there any difference in the health seeking behavior between Norwegian and immigrant women?

This chapter can be considered the most essential in this thesis, as it is through it that the other chapters come together, and the research can be presented in a thorough manner. This chapter represents the culmination of rigorous research, data collection, and analysis. In this pivotal chapter, we delve into the empirical evidence and insights derived from the research conducted in this study. This chapter serves as the bridge between the research objectives established at the outset of the thesis and the meaningful conclusions drawn from the collected data.

Throughout the preceding chapters, the researcher has explored the literature review, theoretical framework, research methodology, and the context within which this study operates. Now, as the research ventures into the findings and analysis chapter, it is the researcher's hope to present the results of the study and the implications they hold.

The first part of this chapter will focus on presenting the findings of the study in such a way that the readers are able to effortlessly comprehend the data. In order to do so, the findings will be divided into topics and each topic will have their own sub-section in the chapter. While the second part of this chapter will focus on closely examining and analyzing each finding and comparing them to the existing body of knowledge.

In order to conduct a proper analysis, it is essential to maintain a critical and objective perspective, this way the study can be able to provide balanced assessment of the data, which hopefully will enable the researcher to reach meaningful conclusions and recommendations in the subsequent chapters. It is the researchers believe that the findings of this study will not only serve as a culmination of this research but will also add in a meaningful way to the already existing body of knowledge on the subject and open more avenues for both future research and practical applications.

4.1 FINDINGS

As previously mentioned, this section of the chapter will focus on presenting the data in a concise manner in order to conduct a subsequent analysis. In order to do so, the researcher has decided to divide this section into topics, each of them consisting of a significant finding of the study. These topics, when analyzed, will be able to provide an overview of women's perceptions regarding their healthcare treatment in the context of the study, potential gaps in the situation, and possible positive things as well. Before starting the analysis, a small, anonymized table with the interviewees is presented in order to provide a little of information about them and allow for a better comprehension of the analysis:

Handle	Nationality	Time Living in Kristiansand
IM01	Brazilian	7 years
IM02	Brazilian	10+ years
IM03	Mexican	3 years
IM04	American	20+ years
IM05	Italian	5 years
IM06	French	10+ years
IM07	Phillipines	10+ years
IM08	Phillipines	10+ years
N01	Norwegian	4 years
N02	Norwegian	10+ years
N03	Norwegian	Whole life (50+ years)
N04	Norwegian	5 years
N05	Norwegian	5 years
N06	Norwegian	Whole life (30+ years)
N07	Norwegian	4 years
N08	Norwegian	Whole life (30+ years)

Finding 1: Ability to communicate in Norwegian

One of the main issues raised by the immigrant women as the fact that they felt a difference in the way they were treated based on their ability to communicate in Norwegian. It was discussed by several of them that when they communicate using English they are often treated poorly or more easily disregarded.

As mentioned by IM01:

> I have experienced it once in my fastlege. I was talking and they were asking about my personal number. And then I started talking in English, I think it was something like that. And then they started speaking Norwegian and said to me, you have to learn it. So there's a pressure for you to learn it, to be able to be properly treated. And I feel that when I spoke only English with them, they had this way of treating you. And they respect you a lot more if you speak with them in Norwegian. Which I don't feel that this should happen.

The ability to communicate in an effective manner is a cornerstone of the quality of healthcare services, for both providers and patients, the ability to both understand and be understood is essential to ensure that a good level of care is provided. It is important to note that even though Norwegian law states that immigrants are entitled to the use of translators when needed during medical treatment, this knowledge was not shared by most of the women interviewed and in addition it was also raised by one that was aware of the existence of this service, that it is not always available due to different situations as mentioned by IM 02, when she talks about:

> in the law they say that you have a right for a translator. Yeah. But it doesn't work as in the law. Sometimes you don't get it. I didn't get it. (…)Communication in English was ok. But I would prefer to have a translator with me. And they didn't have one available. Because it was a small town.

Furthermore, difficulty to communicate properly was raised by IM05, when she stated that:

> it's terrible, because then, again, it's already a very limited consultation. It lasts very short. The person, the doctor's not that into conversation, and then there's a language limiting the doctor to actually give me information. And if she's speaking about me, I feel that I lose control. And I have to rely on a translation, so it's horrible.

While being able to communicate in the local language can be seen as an integral part of social integration, communicating in medical terms can be more challenging and therefore many immigrants can feel anxious when attempting to use Norwegian to describe their medical needs and they can feel that they are not able to properly explain themselves in the language. This point was raised by IM08, when she said that she can speak some Norwegian, however "But especially, for example, if I've been in the doctor or something, I really want English so that I will understand everything".

The lack of willingness by medical personnel to understand this situation can create more barriers to immigrants seeking treatment and affect their overall experiences with the medical system as discussed by IM 06 "she did speak English, but she didn't... She wasn't happy with it. Yeah. To have to speak English. You could see that she was... I could see that that wasn't what she wanted. But that was it. She had to."

The complexity of the relationship between language proficiency and healthcare treatment is of great importance for immigrant's experience with the healthcare system. The difficulties and discrimination that some of the interviewees described in their experiences using a different language when accessing the healthcare system highlights an issue in the healthcare system.

Finding 2: Knowledge of the healthcare system

Access to quality healthcare is a fundamental right, and yet, a significant barrier that hinders individuals from receiving optimal care is the lack of knowledge and information about how the healthcare system works. Health literacy encompasses the ability to access, understand, evaluate, and apply health information to make informed decisions regarding healthcare. This finding focuses on the basic ability of navigating the system and which services are available to everyone.

It was found that Norwegian women were more knowledgeable or at least more confident in their knowledge about the healthcare system and everything that was available to them. Most of the interviewed Norwegian women stated that the best way to use the system is to go through you fastlege and that he will direct you to the correct places. As stated by NO02 “I would contact my fastlege. That's the way I would go. I don't know much more than that because they will refer me if I need anything” and NO03 “It's I call my fastlege and if I need any further treatments, he refers me to whatever I would need like ER or the hospital.” The same was stated by several other Norwegian women. Meanwhile, NO05 stated that “I think it depends on what's wrong with you. It's easy to seek out, but it's harder to actually get the help that you need.”, which demonstrates that even though they may have a better grasp on how to use the system, there are still gaps that they need to face to be properly treated.

There were significant differences between them and immigrant women, mostly due to the fact that there appeared to be no type of information on how the medical system works or even where that information can be found presented to immigrant women when they first moved to the country. Most immigrant women simply received a letter stating who their fastlege was and were expected to be able to navigate the healthcare system on their own. Many of them rely on friends and family to explain things to them.

As stated by IM02:

> I had no information, but I got a letter in my mail, so it came, with very little information about how to use the system, just who my fastlege was and the contact information. It took a little bit of time, but eventually I started learning a little more about how to use the system. I felt myself completely dependent on my husband. It's not a good feeling, I think.

In addition, IM05 also said “I just got the ID number and then I got a letter saying what doctor, I was assigned to a doctor and that was it. And there's no contact detail, and yeah, just that, no other information.” Furthermore, she also stated that:

> I don't think that you have access, it's like there's no easy avenue, it's an open avenue to information, you sort of stumble across on things, upon things, so I think that that hurts the user, and I think that relying only on your doctor for everything.

This is a similar experience to what IM03 describes “I know that I have a doctor and I received a letter. I got my personal number then it said this is your doctor. But I could not make an appointment because I didn’t have bankID yet.” This shows that the information provided to immigrant women on arrival is not sufficient and forces them to rely on others to be able to fulfill a basic need.

Others, such as IM07 apply a learn as you go approach to their use of the healthcare system, as she says:

> I just learned or meet some people that they tell how the healthcare here. So, no. It's like learning. There was no form or explanation of how it works, where to go or anything like that. No. It's like you just learn it when you need to it. So you learn new things.

This adds a burden to seeking healthcare and as IM07 talks about "it's kinda bad, because you can't always know what's gonna happen and sometimes you might not have time to learn what you need before you need it."

It can be said that this lack of forthcoming information creates an added barrier to receiving proper healthcare and that this affects disproportionately more immigrant women as they do not have the benefit of having grown up in the country and having years of previous experiences with the system. As far as Norwegian women's experiences, it appears as their main source of information is simply their fastlege and they rely heavily on them to properly direct them when needed.

Finding 3: Difficulty reaching a doctor or a specialist

Some of the main complaints that were shared by both Norwegian and immigrant women was the difficulty finding a timely appointment with their doctor as well as being able to reach a specialist. The difficulty with finding available appointments was seen to generate a higher level of anxiety and even make people less likely to seek out medical help.

As stated by IM03 "because if I go to the system there's no availability. There's nothing like sometimes like there's like okay one month or two months but by then I'm okay ". This sentiment was also shared by IM06 saying that:

> It takes too long. I know that every time I've tried to get an appointment with my doctor, sometimes it's like three weeks wait. In three weeks, I'm okay. Probably. So it's like, do I even bother? Or maybe in three weeks, it's not my doctor I need, it's a hospital. That is definitely way too long.

In a similar pattern, Norwegian women also had similar complaints, with NO03 saying that she believes that "at the moment my fastlege has very, he has too many patients if you ask me. So from when I order an appointment with him it can take up to a month before I get an appointment." The difficulty with booking even made some Norwegian women decide to not seek out their doctor, with NO05 saying that:

> because if I don't have anything that needs to be sorted right now, there could be a two-week, three-week waiting list. To get an appointment with your doctors. And if not, you

> have to call at, when they open, to get one of those emergency appointments. Which is just stupid. I know that it's hard to get an appointment, so I usually don't go if I don't need to or feel the need to.

In this same sense, NO08 stated that this difficulty makes her feel self-conscious and insecure about seeking medical help, saying that she:

> get really stressed and I hate conflict and I'm really a people pleaser so I'm like, it's okay, I can wait, but I don't want to wait. So then I have to... Yeah. It feels uncomfortable. It makes me feel like, it sucks that I something happened because then I have to go there to get help and they don't seem to actually have the time.

Furthermore, NO07 shared a similar sentiment saying that "the fact that it takes three weeks to get an appointment and you do get there. You feel like you don't want to bother them."

As an opposing side, NO06 believes that the time to get an appointment is not an issue at all and that in her opinion is not something that takes too long, she stated that "you get an appointment relatively fast. I made an appointment one month ago for my doctor. If it's not urgent, I would say that's okay."

Regarding reaching a specialist, it was stated by several different interviewees that the process to reach a specialist is extremely time-consuming and can in cases be very complicated. IM02 stated that "it's still difficult to be in specialists in Norway or to see them. I know where they are, but it's difficult to reach or approach or be referred for treatment there with the specialists."

In addition to this, IM04 mentioned that "And there was no mechanism for us to get in touch with the specialist service". This was something that NO03 also shared, saying that "having to wait too long to go see a specialist in case you needed one". And furthermore, NO08 also stated that she has encountered difficulties in reaching a specialist saying that "it was hard to get to see a specialist. And it was also hard to... I had to argue that it had bothered me long enough to try some medication, stronger medication", demonstrating that she had to advocate for herself in order to be heard and for her issue to be properly addressed.

Meanwhile, NO02 talked about the differences that can happen while looking for a specialist saying that "I think that depends on what's wrong with you. If it's like... I don't know, say something with your muscles for example. You might be put back because it's not as serious." This was a sentiment that was shared by the majority of the interviewees, in which they believed that if they had something that was clearly serious, treatment would be provided quicker.

One of the main issues to needing a consultation with a specialist is the fact that the fastlege might not be able to treat everything, as mentioned by IM01:

> he can do just this because he is not a specialist. He's not a specialist in allergies, he's not a specialist in gynecology. He does like, He puts the fire out. He doesn't actually fix the things that are wrong with me.

An interesting thing raised that goes with what IM01 stated was something stated by NO05, when she said that her fastlege is “open about, this is not my field, I'm going to send you to a specialist.” This difference between actions of fastleges demonstrates that there is no standard that is followed by all, which can create differences in treatment.

While it was mostly common knowledge that a referral from your fastlege was needed in order to get an appointment with a specialist, it was a common factor that this type of referral was not easy to get and even when the fastlege was willing to give a referral, the actual appointment could take months to be booked. This was raised by IM02 “if you get an appointment with a specialist, it maybe takes six months, depending on how serious the problem is, it can take time.” This was shared also by NO04, stating that “and if you want to a specialist or an MR or CT or whatever, you have to wait like 6 months to get it done.”

This means that there is a level of frustration and anxiety that the interviewees had to go through in order to receive care. This is a critical part of health care and the difficulty in accessing shows a significant gap in the system that has negative impacts in the interviewees everyday life. Anxiety, stress, and even depression may ensue as individuals navigate the complexities of the healthcare system. This emotional burden not only impairs their overall quality of life but can also influence health outcomes.

Delayed access to specialized care may allow conditions to deteriorate, potentially affecting prognosis and treatment options. This was an issue raised by IM01:

> And either it's okay, then waiting six months... ...either you're going to be better or you're going to be worse. So either your body gets better by itself or you're in a much worse condition because it takes so long. Yes, it's too extreme.

The difficulties found by both immigrant and Norwegian women with reaching medical professionals shows that there is a significant gap in the system. The fact that many stated that they delay seeking medical care due to this issue shows that the quality of care being given to women is not meeting their needs and it is making them more anxious and uncertain.

Finding 4: Egenandel as a barrier to access to healthcare

In Norway, "egenandel" refers to the patient's share of healthcare costs, which they are required to pay out of their own pocket. This concept is part of the country's healthcare system and is designed to help finance healthcare services and, at the same time, regulate healthcare utilization. Egenandel encompasses various types of patient contributions, including co-payments for doctor visits, hospital stays, prescribed medications, and other healthcare services.

The rising cost of the egenandel was raised by a number of interviewees as something that makes them reconsider seeking medical help. IM05 stated that the need to pay this “pisses me off, because Norwegians tend to believe it's for free for some reason. It's not for free. You pay 2,000 kroner a year, which is... Yeah, you pay your egenandel, and you pay taxes as well”. In addition to this, NO03 shared that this cost causes her to be less secure in her medical care, saying that:

> if I don't have the money to pay for the doctor. Because you have to pay the egnandel up to a certain amount. But being on ufør (disabilities pension[1]*), medication or medical help and is not always easy to afford especially like the first two or three months a year. Until I get the free card.

This barrier created by this cost was also something that caused IM02 to not always seek medical attention, saying that one of the reason for her to delay seeking medical care was “money, maybe. Because you have to pay a bit of it”.

While this barrier was shown to affect both immigrant and Norwegian women, NO02 stated that this cost was not that relevant for her, saying that “of course that we don't have to pay much for it. So you don't have to worry that if you actually end up in the hospital, you don't have to worry about the economy and how to pay for all of this.” This dichotomy demonstrated how the cost can affect vulnerable populations in different ways, which was a point raised by IM06, when she stated both that she finds the:

> egenandel is a bit rough on students. Even if it’s like 250-280? It's actually a considerable amount. For someone without revenue, especially someone from a different country, that was rough. That was too much.

And also, that she finds the *“*Egenandel very smart. Yeah. But mostly for people that can afford it.”

Even though Norway has a universal healthcare system that is primarily funded through taxation, the existence of the egenandel still proves to be a barrier to some in seeking medical help. The purpose of this cost is to ensure that patients have a financial stake in their healthcare

[1] Indirect translation made by writer

decisions and that they contribute to the overall financing of the system, however, when the cost starts making people refrain from using the medical services, there is a need to evaluate its effectiveness.

Finding 5: Difficulty of being heard by doctors

The difficulty experienced by both immigrant and Norwegian-born women in being heard and understood by their doctors emerged as a recurring and concerning theme. This theme underscores the complex dynamics of patient-doctor interactions, which can be influenced by cultural factors, language barriers, and healthcare system challenges. Several participants expressed feelings of mistrust in healthcare professionals, emphasizing that they believe doctors do not fully listen to their concerns. For instance, NO06:

> I cannot say I trust her at all. I haven't I haven't really gotten to know her. And we've only met once for briefly for 15 minutes. I mean, she did. She did go to some extent to take some of my needs into care. But it was a bit of a mix there, to be honest.

IM05 stated:

> Because I think the consultation is too fast, and I'm barely examined, and there's a lot of waiting and a lot of hesitation around prescription, around referrals, I think it's almost like you have to physically fight them to get what you want.

These sentiments suggest a lack of trust and potentially strained doctor-patient relationships, which can impact the quality of care.

Gender-related concerns also played a role in patients feeling unheard. NO02 expressed her preference for a female doctor, stating, "So that's also a bit of why I want to have a new doctor. And now I want to have a female doctor." Meanwhile, NO04 stated:

> Just the particular female parts. I would rather go to a female gynecologist. Have him examine you. But that's kind of a preference. But except for that, it's better to get checked out than to hide something and then find out you checked out too late.

NO07 expressed the following:

> I just want a female doctor because it's not about that really. But it was about... He was just so different from me and he didn't, you know, listen to my... I've had some problems with my menstruation and a lot of pains and wanted to know, like, get a hand listening to a gynecologist. And yeah, and he was just like, oh, that's normal. And I was like, no, I feel like this is not normal.

Meanwhile, NO08 stated,

> When you asked if I've been treated differently because I was a woman, I feel like very many of the men I've seen, they don't know things. And that's why I wanted a female

> doctor. So that's also bad, that I feel like they don't know enough about women's health. Yeah. That's it.

These sentiments suggest that cultural factors sometimes led to male doctors not taking women's health problems seriously, revealing an additional layer of complexity in doctor-patient interactions.

Furthermore, the rushed nature of doctor's appointments was a common complaint. IM05 expressed dissatisfaction with the level of information and decision-making support provided by medical personnel. They feel that appointments are too short, typically lasting only 10 to 15 minutes, making it difficult to receive the necessary information and explain their health issues adequately. IM05 stated, “So you just feel like it's too rushed and there's no... No, it's go, go, go, next, next, next.” This rushed environment leaves them feeling that the medical process is too hurried and lacks the necessary attention. NO07 acknowledged that doctor appointments for non-childbirth related issues often felt rushed due to limited time and the doctors being frequently late, stating that:

> You know, you feel like the appointments are kind of rushed. Yeah, of course. They have a limited time. Yeah. They're always late. I have like I had the same doctor now for maybe, oh, maybe 10 years. Yeah. She knows me well, you know, always when I book an appointment, it's like three weeks in ahead. Yeah, they're always late. She's always she tries to make time for me and like see me when I come into the office. But I know she's stressed. Things go very quickly.

When asked if they feel like they are rushed out, NO08 agreed, stating that, “Yeah. Yeah. I feel like everything is very rushed. Yeah.” Overall, these time constraints can hinder effective communication and contribute to patients feeling overlooked.

However, participants, especially those who were Norwegian-born, recognized the importance of self-advocacy. NO06 highlighted this by stating, “so you have to be much, much bigger advocate for yourself and much more vocal in order to get any type of care.” This highlights that individuals have to be strong advocates for their own healthcare and be more vocal to receive the care they need. Accordingly, patients need to actively assert their concerns and advocate for their health, suggesting that patient involvement is vital to ensure they are heard by healthcare professionals.

In conclusion, the interviews reveal that the difficulty of being heard by doctors is a multifaceted issue encompassing trust, gender, rushed appointments, and the importance of self-advocacy. These findings emphasize the need for improvements in doctor-patient interactions and the overall healthcare experience in Norway, with a focus on fostering trust,

addressing language and cultural barriers, and allowing for more time for meaningful patient-doctor dialogues.

Finding 6: Change in seeking help behavior for immigrant women.

The interviews with immigrant women in Norway reveal a significant shift in their healthcare-seeking behavior. Immigrant women often find it challenging to grasp how to utilize the medical services in their new country because they come from a place with a different system of healthcare. IM0 mentioned, “Well, it’s very hard coming from a different country with a different style of medical services and trying to understand how everything works here.” Meanwhile, IM04 stated:

> And I came home and said to my husband, if I get seriously ill, you put me on the first plane home. Because I'm not going to this hospital. It's better now. Yeah, but both from the working side that you had and the immigrant side, there was no explanation of how anything in the healthcare worked. You were just kind of thrown... I was told where to go to get a uniform to put on so I could go to work.

Overall, this change indicates a greater inclination toward proactive healthcare. It appears that, back in the immigrants’ home countries, reliance on home remedies is common, but in Norway, seeking medical help for even minor health concerns is considered a safer option.

Language barriers and the fear of miscommunication significantly affect the healthcare behavior of immigrant women. IM05 claimed that:

> The person, the doctor's not that into conversation, and then there's a language limiting the doctor to actually give me information. And if she's speaking in the region about me, I feel that I lose control. And I have to rely on a translation, so it's horrible.

IM06 stated:

> I hope she would have done better in Norwegian. I hope that she would have been more nuanced in Norwegian. But the English came really, really wrong. And it sounded very much like she just took a shortcut to avoid having to look for her words or anything. So, language can be a barrier.

This underscores the impact of communication difficulties, which may significantly affect the healthcare behavior of immigrant women.

The immigrant women acknowledged the differences in healthcare systems between Norway and their home countries. IM02 stated:

> If you have kids in Norway, you have much better treatments than when you come here as an adult person. And maybe they could just do the same thing they do when they protect the kids so much. And have a good system that takes care of all the family. And it's not

> just to treat the problem, they treat all, they surround that family with care. But when you are an adult, you don't even need to follow a rule of a doctor if you don't want to. And I think this is weird. I cannot, for example, access to my daughter's medical reports. I cannot get any information after she is 16 or 18, I don't remember. I cannot know anything about her. If she is sick, if she is not sick. If she is 16 and has an abortion. I don't even have the right to know if she doesn't want to.

This shift represents the transition from relying on alternative medicine in their home country to adapting to the Western healthcare system in Norway, which emphasizes doctors and medications.

In conclusion, the interviews shed light on the transformation in healthcare-seeking behavior among immigrant women in Norway. Factors such as language barriers and adaptation to a different healthcare system have led them to seek help more promptly and discuss health issues more openly, challenging cultural norms and taboos in the process.

Finding 7: The lack of preventive medicine

The interviews with both immigrants and Norwegian-born individuals shed light on a concerning theme within the healthcare system— the lack of emphasis on preventive medicine. IM01 mentioned, “I think more preventive medicine,” when asked what they would change about healthcare provision in the Norwegian healthcare system. Moreover, other immigrants reinforced this sentiment. IM02 stated, “It's difficult...They don't send you to a specialist just because you want to know if you have something. You have to have concrete symptoms before you are able to see a specialist.” IM03 mentioned, “Yeah, it's like well, we don't know what to do. Like they just don't investigate your problem. There's no preventive or there's no proactiveness in it.” IM04 expressed, “It's there, but it's not always used.” IM05 stated, “Not at all. Not at all. And it's unsafe." IM06 stated, “I think there is a wonderful effort of preventing medicine on the psychological part. Like psychological help, there is a lot of prevention for this. But actual medicine, not so much.” These participants from various backgrounds all echo a common sentiment that the healthcare system tends to prioritize treating illnesses when they occur rather than actively promoting measures to prevent them. It became evident that individuals often had to push for preventive care and regular check-ups themselves.

Norwegian-born participants shared similar concerns about the healthcare system's lack of emphasis on prevention. NO01 commented:

> like you just mentioned like maybe you would like him to be a little more hands-on yeah like be a little bit more preventive be a little bit more all right so this is your symptom we're gonna figure out what is wrong.

NO08 noted:

> Yeah. Maybe they could, sometimes I feel like maybe they should have taken more tests. Actually, like look at me if I come with like a physical problem. I feel like maybe I feel like they should check it out and not just like listen to me describe it. Yeah. Behind their desk.

These sentiments demonstrate that the system was more reactive than proactive, which might lead to missed opportunities for early intervention.

In sum, the interviews brought to light a shared concern about the healthcare system's failure to prioritize preventive medicine. Whether immigrants or Norwegian-born, participants expressed the need for a shift towards a more proactive approach, including regular check-ups and greater guidance on preventive measures, which could ultimately lead to improved overall health and more cost-effective healthcare in the long run.

Finding 8: Use of paracetamol for everything

Participants gave insights about their behaviors and perceptions of paracetamol self-medication and the broader healthcare system. When experiencing mild symptoms or discomfort, it is normal practice to wait and self-medicate with paracetamol, according to IM01. IM01 stated:

> In the beginning, I would do it right in the beginning. Like, okay, I have started feeling this and this and this. And I'm going to try to find help. But after Corona, I try to wait and see if I'm going to get better by myself. Because that's what I feel. That if you go right in the beginning, when you start feeling symptoms, it's like, okay, but your body is going to fight by itself. Go and take a paracetamol. And go home and relax. So, if I don't get better within some days, then I go and search for help.

The belief is that the body can naturally overcome the issue, and the initial step is often to take paracetamol at home. Furthermore, there is a prevalent reluctance among many people, both immigrants and potentially Norwegians, to seek medical assistance. IM01 pointed out that they often feel that their health issues might not necessitate a visit to the doctor and can be managed with paracetamol at home. IM01 stated:

> I think if you can't prevent something, it's much better than you have to take an action after things have actually happened. And I do feel that many people here, they wait until the situation is way too bad to take an action because they don't want to go. They think that it’s not worth going to the doctor, if you are feeling pain, you're going to get a paracetamol. Then I don't go to the doctor because I can take paracetamol at home.”

This reluctance stems from the perception that a doctor's visit may not be worth the time and effort if the solution is as simple as taking paracetamol.

Additionally, IM03 expressed a sense of frustration with the healthcare system, particularly when dealing with symptoms that are not easily diagnosed. This participant highlighted that healthcare professionals sometimes recommend paracetamol as a solution without fully understanding or addressing the underlying issues. IM03 stated:

> It's easy if you call and tell that it's serious. Then they tell you yeah, you can come or you can wait a little longer. It's like a very difficult question for me because they do help but it's not so much of a help. That's why I don't go anymore. It's like just take your paracetamol.

This perceived limited help from medical professionals can lead to frustration, potentially discouraging individuals from seeking necessary medical assistance.

Furthermore, IM07 emphasized concern about the overreliance on paracetamol as a common remedy for various health issues. When asked what other part of the medical care that they did not like, IM07 stated, "Yeah. And too much paracetamol. Too much paracetamol." This indicates that paracetamol is often used as a default solution, potentially resulting in individuals not seeking essential medical care when it is needed.

Overall, these findings demonstrate that some immigrants are accustomed to taking paracetamol first when experiencing minor health problems. As part of this practice, individuals are also unwilling to seek medical help in case they believe that one is suffering from what may seem like minor symptoms. Moreover, this is primarily because of the common recommendation of paracetamol as a solution.

4.2 ANALYSIS

In this section, attention will be directed towards a comprehensive analysis of the study's findings, illuminating how they address the research questions at hand. These findings will be meticulously correlated with the established body of literature, ensuring a seamless alignment with the theoretical framework underpinning this research.

Research Question 1: To what extent does women's perception of their medical treatment affect their quality of life?

This study highlights the profound influence of women's perceptions of medical treatment on their quality of life within Norway's healthcare system. Central to the concern is the communication barrier that especially affects immigrant women. Healthcare services

greatly depend on language proficiency. This coincides well with The Theory of Compassionate Care, which emphasizes empathy and providing patient-centered care (George, 2022). Inadequate communication with healthcare providers, particularly when English is the default language, can leave patients feeling ignored and devalued, which violates the fundamental principle of the compassion theory (Sinclair et al., 2012). The issue leads to increased stress, anxiety, and discrimination, negatively affecting overall quality of life. Such experiences are consistent with previous literature on women's healthcare, in which language barriers cause women to feel ignored and underserved, leading to delayed diagnosis and inadequate treatment (Barker, 2011; Walsh et al., 2019).

Furthermore, the analysis reveals that lack of information and knowledge about Norwegian health system is a huge challenge for these immigrant women whereby they have been forced to seek help from their friends and family. Dependency and uncertainty aggravate their poor quality of life due to the absence of guidance. This lack of knowledge is consistent with the findings by Mochache et al. (2020) concerning the need to understand the context and social factors influencing women's health seeking behavior. Additionally, it shows how institutional power dynamics impact healthcare experiences, particularly when power structures determine access to resources and information (Foucault, 1979). Lack of guidance creates dependency and uncertainty, further exacerbating the overall quality of life. In this context, Foucault's "medical gaze" becomes extremely important because this concept addresses the role played by healthcare facilities in shaping patients' healthcare experience. Specifically, Foucault (1979) points out how knowledge and information are distributed within the system.

Accessing specialist care is challenging, especially with long wait times and appointment difficulties, which affect both immigrants and Norwegian-born women. Delays cause deterioration in health and stress, which is exacerbated by the financial burden of patient co-payments, which is a significant problem for immigrants and discourages them from seeking medical care. Financial disparities exacerbate the impacts, illustrating how institutional power influences individuals differently depending on their financial situation. This is consistent with Foucault's concept of biopower, which emphasizes control over an individual's well-being and body (Foucault, 1979). These concerns parallel previous studies on healthcare disparities, especially regarding specialist visits, which may result in delayed treatment and deterioration of health (Hansen & Høye (2015).

Women in both groups experiences challenges being heard by doctors which created strained doctor-patient relations and emotional distress and had impact on their general health.

The healthcare system's emphasis on reactive care rather than preventative medicine was a major cause of concern. This shortcoming may result in missed opportunities for early intervention, which might be detrimental to general health and quality of life.

Women may be discouraged from seeking medical care if they lack trust and feel ignored (Tait et al., 2009). These concerns are consistent with Gender Theory, since they represent how gender stereotypes impact the perception and handling of women's health problems, frequently leading to symptom disapproval. This bias emphasizes power relations in healthcare as well as cultural norms influencing gender roles (Jule, 2014). The minimal emphasis on preventative care emphasizes the necessity for patient-centered healthcare that addresses the unique needs of women.

Routine use of paracetamol for minor health issues may result in late diagnosis and treatment hence affect long term wellbeing. This practice makes it more difficult for women to seek medical care when they need to and calls for a better knowledge of women's health issues (Walsh et al., 2019). It has a close connection to Gender Theory as well as gender stereotypes that influence women to downplay symptoms, self-diagnose, and forego seeking healthcare (Saltonstall, 1993). Refusal of these women to seek prompt medical attention is detrimental to their quality of life.

To summarize, women's perceptions of medical treatment have a substantial impact on their quality of life in Norway, particularly for immigrant women who face communication barriers, a lack of knowledge about the healthcare system, and difficulty accessing healthcare services. Trust, preventative care, and effective communication are critical aspects in enhancing healthcare experiences and overall quality of life in the Norwegian healthcare system, emphasizing the need of patient-centered care and support.

Research Question 2: To what extent do women in Kristiansand believe the medical treatment they receive is adequate to their needs?

Healthcare challenges persist for immigrant and Norwegian-born women in Kristiansand, Norway, most significantly as a result of language barriers. These obstacles align with global research, resulting in symptom dismissal and late diagnosis. Gender bias further impacts healthcare experiences, as seen in Hansen & Høye (2015). Empathy, as emphasized in the Theory of Compassionate Care (George, 2022), is crucial. Language obstacles are highlighted as a power dynamic impacting doctor-patient relationships in Foucault's Theory of Power (Foucault, 1979), while Gender Theory argues that immigrant women may suffer

language-related stereotypes. A more inclusive, patient-centered strategy is required to enhance women's healthcare experiences in Kristiansand, regardless of their background.

The analysis emphasizes the value of healthcare system knowledge, and the challenges immigrant women face in accessing care. Disparities still exist, limiting women's access to healthcare even in Norway, a country known for gender equality (Gustafsson Sendén et al., 2020). The challenges faced by immigrant women are consistent with the Theory of Compassionate Care, which holds that delayed medical assistance seeking might be caused by ignorance, hence negatively affecting the patient's experience (George, 2022). The complicated healthcare system serves as a representation of institutional power that has an impact on patients, which is significant to Foucault's Theory of Power (Foucault, 1979). Gender stereotypes may also play a role, since social norms tend to underestimate women's capacity to navigate complex systems.

The difficulty of accessing specialists and long wait times, in line with prior research, underscores healthcare access disparities for women, potentially causing anxiety and delaying treatment-seeking (Hansen & Høye, 2015; Gustafsson Sendén et al., 2020). This issue reinforces gender disparities in healthcare and is consistent with Foucault's Theory of Power, which postulates that institutional structures can produce differences in access that are shaped by social norms (Foucault, 1979). The concept of "biopower" is particularly relevant since it illustrates how gender norms in society and culture affect access to specialists (Foucault, 1979).

Egenandel, or out-of-pocket costs, may act as significant barriers to access to healthcare and thus discourage individuals from seeking necessary care. The Theory of Compassionate Care underscores the need for patient cost awareness (George, 2022). The Theory of Power by Foucault pertains to this barrier since financial barriers represent power dynamics. Gender theory is also applicable, as financial disparities disproportionately impact on women because of societal norms.

Difficulty being heard and rushed appointments erode trust in doctor-patient relationships. This finding is consistent with previous research, with patients often stating that they feel their concerns go unheard (Barker, 2011; Hoffmann & Tarzian, 2001). These findings correlate with the Theory of Compassionate Care which stresses empathy and trust. Foucault's theory of power also matters because power imbalances affect patient communication (Foucault, 1979). Gender stereotypes may additionally affect the quality of doctor-patient interactions, especially for women.

Interviews with immigrant women in Norway demonstrate that language barriers, disparities in the healthcare system, and the necessity for proactive care have all contributed to

a change in the manner that women seek medical attention. This takes into account cultural considerations and system adaptability (Mochache et al., 2020). This shift is congruent with gender theory and connects with Foucault's concepts of resistance as immigrant women may explore alternative healthcare approaches (Foucault, 1979).

The healthcare system's limited focus on preventive medicine raises concerns as it tends to be more reactive than proactive. Studies indicate that most healthcare systems focus on treating diseases instead of prevention, which might be a missed opportunity towards early intervention (Nasrabadi et al., 2015). Participants advocate for a shift toward proactive approaches, such as regular check-ups, reflecting the Theory of Compassionate care, which emphasizes patient-centered care (George, 2022). According to Foucault's Theory of Power, reactive treatment reflects institutional power dynamics (Foucault, 1979). Gender Theory is significant because this approach can have a disproportionate effect on women's healthcare. Ultimately, the healthcare system needs a more comprehensive, gender-sensitive, and proactive strategy that prioritizes prevention and early intervention.

Finally, the widespread use of paracetamol as the quick solution to any health problem and the avoidance of proper medical consultation also contribute to low-quality medical care. Such dependence upon self-medication and reluctance to consult a doctor could perhaps be the extension of a wider trend observed among women, who tend to delay seeking medical assistance when they have minor concerns (Juvrud & Rennels, 2017). Participants expressed frustration with the healthcare system's reliance on paracetamol, illustrating concerns about undertreatment and its consequences for women's well-being (Walsh et al., 2019). This is consistent with Gender Theory in that societal stereotypes may contribute to women delayed medical seeking behaviors. It is consistent with the Theory of Compassionate Care, affecting patient care and quality of life (George, 2022).

Conclusively, findings reveal that immigrant and Norwegian-born women in Kristiansand encounter healthcare access challenges because of language barriers, lack of system knowledge, specialist unavailability, financial difficulties, and doctor-patient interaction issues, which influence their perception of medical care adequacy. Women in Kristiansand must receive personalized healthcare that addresses their concerns, enhances preventive care, and improves communications.

Research Question 3: Is there any difference in the perception of treatment between immigrant women and Norwegian-born women?

In Norway, there are notable differences in treatment perceptions between immigrant and Norwegian-born women. Language barriers are a major obstacle for immigrant women, influencing their sense of care. They believe that their ability to communicate in Norwegian has a substantial impact on their treatment, resulting in a sense of inequality. This is consistent with Foucault's Theory of Power, which demonstrates how power dynamics affect access to care (Foucault, 1979). Gender expectations also influence barriers to communication (Courtenay, 2000). Norwegian-born women, who lack these linguistic barriers, do not share this viewpoint. This is an issue that affects immigrant women who face language barriers (Amundsen et al., 2019).

Norwegian-born women have better knowledge of the Norwegian healthcare system and its mechanism as well as navigating it through their general practitioner, while immigrant women are usually deprived of essential information regarding healthcare and are usually less informed about their options. This finding is coherent with Foucault's Power/Knowledge theory, which highlights how medical knowledge can amplify gender stereotypes (Foucault, 1979). It also interacts with Gender Theory concerning gender stereotypes (Jule, 2014).

Women, whether immigrants or Norwegian-born, face long waiting time and experience anxiousness in seeking specialist care. This negative perception of the healthcare system aligns with the existing gender disparities in access to healthcare (Hansen & Høye, 2015). This finding highlights the impact of power structures on access to specialist care and its connection with Foucault's Theory of Power (Foucault, 1979). Gender theory is also pertinent, stressing out the fact that gender can influence health issue treatment (Pylypa, 1988).

Egenandel can be a barrier for immigrant women with limited finances, while Norwegian-born women may not face the same hurdle due to their economic status. Contrarily, for Norwegian-born women, it is possible that this particular hurdle does not affect them much due to the fact that they are much more financially stable. Walsh et al., (2019) supports this finding by arguing that financial access affects women's healthcare experiences. Gender Theory emphasizes the importance of social and economic aspects in women's healthcare (Vlassof, 1994). Moreover, Foucault's Theory of Power (Foucault, 1979) illustrates how financial barriers can perpetuate power imbalances.

Both immigrant and Norwegian-born women face common concerns when it comes to healthcare experiences. Their common views on gender-related concerns, rushed doctor appointments, and the need for self-advocacy have an impact on care quality. This is consistent with other research (Barker, 2011; Werner & Maltervud, 2003) that demonstrates how women's symptoms are often written off or misinterpreted as psychological issues, leaving them with

the impression that they are not being taken serious (Tait et al., 2009). According to Foucault's Theory of Power (Foucault, 1979) and Gender Theory (Jule, 2014), which emphasize gender-based disparities in healthcare, this delay in treatment may result in prolonged suffering and frustration. Both immigrant and Norwegian-born women experience a sense of frustration and helplessness in the face of the medical gaze, where clinicians may objectify patients.

Health-seeking behaviors among immigrant women in Norway differ significantly with their healthcare-seeking experience in their home countries, characterized by more prompt and open discussions about health issues. The major cause of this shift is the variations in the health systems and language barriers. Moreover, Foucault's theory of power highlights the adaptation of individuals to societal norms and power dynamics (Foucault, 1979), while gender theory emphasizes the role of gender stereotypes on healthcare behavior (Courtenay, 2000).

The Norwegian healthcare system seems not to emphasize more on preventative medicine as per the perceptions of both immigrant and Norwegian-born women. Both groups share a need for more proactive healthcare measures such as routine check-ups that are not prevalent. The need for more proactive healthcare measures by both immigrant and Norwegian-born women mirrors the debate around cultural influences on women's health behavior in literature (Mochache, et al. 2020). This finding is in line with theory of power by Foucault (1979), which highlights the concept of medicalization and how some women's health concerns might receive preferences than others. Additionally, gender theory is pertinent as it explores the influence of societal norms in women's health care (Jule, 2014).

Some immigrants commonly use paracetamol as an initial remedy for minor health conditions, often because they believe doctors recommend it without addressing underlying issues. This practice reflects a broader issue of women's symptoms being disregarded or undertreated, as observed by Walsh et al. (2019). It is consistent with Foucault's Theory of Power (1979) and the medical gaze concept, in which healthcare practitioners may undertreat the symptoms of women. It is also linked to the impact of gender stereotypes on healthcare behaviors, as addressed by Courtenay (2000).

In conclusion, immigrant and Norwegian-born women perceive treatment differently. Factors include language barriers, understanding of the healthcare system, access to specialists, finances, doctor-patient communication, shifts in the behavior of seeking medical attention, lack of preventative medicine, and widespread use of paracetamol. These dynamics underscore the complexity of the Norwegian healthcare system's impact on various population segments.

Research Question 4: Is there a different in health seeking behavior between immigrant and Norwegian born women? Do immigrant women change their behavior after immigrating?

Immigrant women in Norway have different health-seeking behaviors than Norwegian-born women. Language proficiency and communication issues while seeking healthcare services often impact their behavior after immigration. Inadequate language skills can lead to perceived discrimination and disrespect, therefore proficiency in Norwegian is critical for effective healthcare interactions. According to research, host nation language proficiency is critical for quality healthcare (Lien, 2021; Mochache et al., 2020). Language barriers lead to discrimination, impacting the treatment and respect levels of immigrant women (Mochache et al., 2020). The Theory of Power by Foucault, which emphasizes linguistic dynamics, is essential, providing light on healthcare practitioners' linguistic dynamics. The concepts of power/knowledge and the medical gaze demonstrate how language barriers reinforce power differentials (Foucault, 1979).

Norwegian-born women possess greater healthcare system knowledge due to information and guidance, while immigrant women often depend on family and friends. This illustrates how social and cultural norms influence individual's decisions to seek medical attention (Mochache et al., 2020). The reliance of immigrant women on social networks emphasizes the need of cultural adaptation and support systems (Mochache et al., 2020). These findings are consistent with Gender Theory, which emphasizes the influence of cultural norms on healthcare behavior and reinforces gender stereotypes. Gender Theory emphasizes how social networks shape women's understanding of the healthcare system, which is influenced by gender norms and roles (Jule, 2014).

Immigrant and Norwegian-born women both encounter challenges accessing timely medical appointments, potentially causing anxiety and deterring care-seeking. Studies from Norway and other Scandinavian countries (Hansen & Høye, 2015; Gustafsson Sendén et al., 2020) clearly show disparities in healthcare access depending on gender. Given that these challenges are seen as expressions of power dynamics, Foucault's Theory of Power is pertinent. According to Foucault (1979), institutional power clarifies how institutions influence individuals' access to and experiences with healthcare.

The egenandel can deter medical help-seeking, especially among financially constrained immigrants. This is related to Foucault's Theory of Power, which holds that financial obstacles represent an unequal distribution of power in healthcare access. Foucault's concept of biopower, which includes control over one's well-being, including financial elements, has an impact on this (Foucault, 1979).

Both groups struggle to be heard and understood by healthcare providers, influenced by rushed appointments, mistrust and gender-related issues. The Theory of Compassionate Care is pertinent in this case because it focuses on improving relationships and communication in healthcare, as well as improving how women are heard and respected (George, 2022).

Norway's healthcare system faced criticism from both immigrant and Norwegian-born women for its limited focus on preventive medicine, resulting in a more reactive approach to healthcare. Hansen & Høye (2015) and Gustafsson Sendén et al. (2020) studies emphasize the need of a proactive healthcare approach, including frequent check-ups and preventative guidance. Prioritizing preventive medicine can improve overall health while also promoting cost-effective healthcare. The Theory of Compassionate care becomes significant as it connects with the quality of care and prevention guidance women receive. As established by Fogarty et al. (1999), compassionate care enhances patient experiences and life quality, underlining the necessity of preventative medicine.

Paracetamol emerged as an often first response for minor health issues, potentially due to misconceptions about its effectiveness. Gender bias in healthcare, as discussed by Walsh et al. (2019) and Juvrud & Rennels (2017), can impact women's healthcare decisions. Gender Theory, specifically focusing on stereotypes, is relevant here, showing how biases affect perceptions of treatment adequacy and help-seeking behavior. Courtenay's (1998) insights into how gender stereotypes influence health-seeking behavior are particularly applicable when assessing treatment adequacy and seeking medical assistance.

Immigrant women in Norway exhibit transformed healthcare-seeking behavior, actively seeking medical help for minor health issues compared to their home countries. This shift results from language barriers, cultural adaptation, and disparities in healthcare systems (Mochache et al., 2020). These factors, including language obstacles, cultural adaptation, and the unique healthcare system, prompt timely medical assistance and more open health discussions. Gender Theory, particularly concerning gender stereotypes, is pertinent, as it investigates how cultural adaptation and language barriers impact healthcare behavior within the context of gender expectations (Courtenay, 2000). Gender Theory underscores the influence of socially constructed gender stereotypes on the altered behavior of immigrant women due to cultural adaptation.

In summary, the findings show that Norwegian-born women and immigrants have different healthcare-seeking behaviors that are impacted by language, cultural factors, healthcare system knowledge, and system features. After migrating to Norway, immigrant women particularly often exhibit more proactive healthcare-seeking behavior. These findings

highlight the necessity of tailored approaches to healthcare communication, information dissemination, and system improvements in order to better meet the diverse needs of immigrant women and promote a more preventative approach to healthcare.

5. CONCLUSION

After analysing the way that the way that women in Kristiansand perception of their healthcare treatment is, it is this researcher's opinion that there are still many areas in which improvements can be made in order to provide a service that is better suited to their needs and wants. There were clear patterns that emerged in the analysis that highlighted situations in which women feel anxious and not heard in their medical encounters.

This signifies that their experiences are being impacted in a negative manner and have a negative consequence in their everyday lives. While there were also positive things, particularly the idea that if something serious happens to them they would be taken care of, there was a fear that minor symptoms and medical issues were not properly treated until they evolved into something more serious. This creates uncertainty and insecurity, which are not things one would want to be connected to their medical treatment.

It was demonstrated that the way the medical system works, and the way that doctors talk to patients creates an imbalanced power relationship, which creates more barriers to access to proper medical care. This appeared to be heightened by gender stereotypes that are at play in those interactions. Those were issues that affected all of the interviewees to the same degree, without any significant differences being found between the different groups of Norwegian and Immigrants. All of this demonstrates the necessity for a more empathetic care, which this thesis suggests should be based on the Compassionate Care Theory.

One of the issues that was significantly different between the groups was the ability to properly understand and navigate the healthcare system and the options available for you. It became clear throughout the study that immigrant women are at a high disadvantage, and this makes them become more reliant on personal connections, which can put them in vulnerable situations if those connections are not willingly to provide them with correct information, whether intentionally or unintentionally.

Something that it was interesting was the fact that immigrant women, independent of their country of origin, appear to change their behavior regarding their willingness to seek out medical help after living in Norway for longer periods. The most common barrier that caused this was the amount of time that it takes to be able to get an appointment with your own fastlege, with many women mentioning that they simply prefer to wait, see, and hope that they improve instead of wasting time and stressing about the situation. This provides a possible future area to be researched in Norway, to better understand how and why this situation happens and the possible impacts this has on immigrants' experiences in the country.

While the findings in this study carry significance and help provide more insight into the way women's experience their healthcare in Norway, there is still much that needs to be addressed and studied in the country. As this study highlights, there are significant issues that affect women's experiences in a very negative manner, and they must be properly tackled in order to improve their perceptions of their medical treatment in the country. This also means that this field of study is still one that has many opportunities for researchers and that there is much that can be added to the field of knowledge.

In the next sections of this chapter, the researcher will talk about what the study limitations look like and discuss them. It is possible that more exist, and that the researcher was not able to perceive all of them. After that, some tentative policy implementations will be suggested that have as a goal address the gaps in the medical care raised by the findings, providing possible solutions to address them and hopefully improve women's perceptions of their medical care.

5.1 STUDY LIMITATIONS:

As with every study, this thesis also has its own limitations as well as ethical challenges that need to be addressed. It is the researcher's opinion that the main ethical challenge in this thesis is impartiality. As with any qualitative study, this is as imperative part and also one of the hardest. In order to remain as impartial as possible, the researchers attempted to allow the data to guide the study and challenge pre-conceptions in order to conduct a proper analysis. The use of both inductive and deductive methods of analysis was applied in order to attempt to diminish bias in the analysis, but of course it is possible that a certain level of bias can still be found.

Furthermore, other limitations of this thesis are: the use of only one city in Norway, therefore it is no possible to state that the issues and positives occur in the country, but may be confined to a small region; the lack of inclusions of other genders or non-gendered people into the study and the impacts that they also suffer and their own perceptions of the healthcare. The reason why those avenues were not pursued during this thesis is the lack of time to do so. Despite a willingness from the researcher to also address those points, there was a limitation to what was realistic to conduct in for this thesis. This thesis relies on previous studies, as demonstrated by the literature review in order to provide a foundation for comparison with what has been found in other regions and with the inclusion of other genders.

Another limitation of this study is the lack of possibility of replicability or generalization of this study. This, however, is a usual fact when conducting qualitative research

as it is intrinsic to this type of research, but it would be a mistake to not raise this fact. While this thesis aims to provide in-depth and nuanced analysis of this phenomenon in the city of Kristiansand, it is possible that with different interviewees the result might have yielded different results. This is something that is impossible to predict with qualitative research, but the research stands by the results achieved in this thesis.

5.2 POLICY RECOMMENDATIONS:

Based on the findings in this study, it is this researcher's opinion that there are three possible policies that can be implemented in order to address the gaps and problems found during this study.

Policy 1: Medical training on more empathetic care, based on compassionate care theory

During the literature review, it was mentioned that there are initiatives focused on reducing bias in healthcare in Sweden, as stated by Dellenborg et al. (2019), This study highlights the need for such in Norway, as well as trainings that have a broader scope. It was shown in this study that there are power imbalances between women receiving medical care and medical personnel, as well as language barriers, lack of empathy and gender stereotypes that make it harder for women to feel heard.

Therefore, this researcher recommends the implementation of training for medical personnel aimed at enhancing their empathy when treating women, by integrating courses based on Compassionate Care Theory in their medical training as well as having initiatives for continuous training throughout their careers, such as workshop and online courses. This would involve putting a higher empathizes on the importance of applying empathy to their doctor-patient relationship, by understanding the patient's perspectives, being more sensitive to different backgrounds as well as learning communication techniques that attempt to humanize the medical encounter and diminish the power imbalances intrinsic to it.

In addition, it is also important to have some form of regular assessment to ensure that these trainings are meeting its objectives, so this research suggests having yearly feedback surveys sent to patients to serve as performance evaluations. This would help guarantee that patients and particularly women's experiences and perceptions of the medical care is improving and help identify any further gaps that need to be addressed to make certain that the healthcare system is providing a safe and welcoming environment for its users.

Policy 2: Improving information supplied to immigrants upon arrival regarding the medical system

As demonstrated in this thesis, one of the main issues raised by immigrants was their lack of knowledge and their uncertainty of how to properly use the medical system. Therefore, this policy aims to improve the information provided to them on their arrival. This policy recommendation is for the development and distribution of a more comprehensive healthcare guide that can be send with their information letter, containing at least two different languages in the physical copy: Norwegian and English, as it is often the reality that new immigrants are not able to read Norwegian and this information is too important to only be provided in one language. It is also recommended that this information is made easily accessible online, with more languages available. This guide should include information about how the healthcare system works, what are the types of services that are available, how the egenandel works and details about where and how to find more information should it be necessary.

The implementation of this policy has the goal to provide immigrants with the knowledge required to make informed decisions about their own health and well-being, without needing to rely on others to provide them with information. This ultimately helps promote a higher level of access and proper utilization of the healthcare system, being able to attempt to diminish improper use and waste of resources.

While this policy should be aimed at all immigrants and not only women, it is important to state that the need for it was made clear by the women that were interviewed for this study.

Policy 3: Investing in preventive medicine

One of the main difficulties raised by the interviewees in this thesis was the fact that they felt that they needed to wait until their symptoms became something serious before receiving proper care. This was a common issue between both Norwegian and immigrant women and points to a significant gap in the medical treatment in the country. It is common knowledge that preventive medicine can be costly, however "most preventive health strategies lead to cost savings that far outweigh the cost of their implementation"[2].

This means that even though it can have a high initial cost to implement, in the long run, these initiatives would actually mean savings for the government in their expenditures. This is due to the fact that you are treating diseases at their early stages, where it is usually cheaper and easier to address them, whether than waiting until they develop to levels that

[2] https://preventioncentre.org.au/about-prevention/what-are-the-economic-benefits-of-prevention/#:~:text=Many%20preventive%20health%20interventions%20may,need%20to%20treat%20expensive%20diseases.

require a higher level of medical interventions, such as surgeries, continuous treatment, or hospitalizations.

This policy would focus on implementing more screening and early detections programs, which can allow patients to feel better cared for and more heard from the beginning of their medical interaction. This would also mean creating a more streamlined referral system, that can allow patients to reach specialists in a more timely manner, which was an important issue raised in this study.

Another strategy suggested is also focusing on health education and promotion campaigns. This goes hand in hand with the previous policy and refers to the amount of knowledge about the healthcare system and how it can impact your usage of it. Creating more awareness of the medical system through public awareness campaigns and ensuring that the public is aware of the medical system as well as steps that they can take to help improve their own health without requiring medical attention is imperative for preventive medicine.

5.3 FINAL THOUGHTS

This thesis set out to evaluate the way what women in Kristiansand perceptions of their medical care in the city was. Throughout the interview process, this research was made aware of significant gaps that the women interviewed felt created barriers, difficulties or made their medical encounters uncomfortable. They expressed concerns regarding the way that the lack of timely access to doctor's can impact their decision-making process to seek out medical help, as well as stated that there is a level of anxiety and uncertainty added to their everyday lives due to this difficulty. In counterbalance, it was also found that this anxiety does not translate in the event of having a serious disease, as it was an overall believe that in that situation, they would be taken care of. The question that must asked then is: why must they wait until something serious happened in order to feel like they are able to receive proper medical care?

This thesis talked about the need for more Compassionate Care theory to implemented to the medical encounters in the country and the pervasive effects of gender bias and the power imbalances in the patient-doctor relationship. It is this researcher's hope that this thesis contributes to this situation, by helping shed light on the situation and with the policy recommendations demonstrating that there are concrete steps that can be taken to attempt to mitigate the issues raised through this study.

This study also demonstrates that there are still much that needs to be studied and learned regarding women's medical treatment in Norway and the different barriers and difficulties that Norwegian and immigrant women face. While there is not way of ensuring that

everyone’s experiences are positive, it is this researcher believe and hope that this thesis can contribute to improvements in the situation. This thesis discussed the complicated and nuanced interplay that exists in women’s perceptions of their medical care, showing that societal influences, power structures and imbalances, gender stereotypes and empathy all play a part in their perceptions. This thesis advocates for a more empathic and patient-centric approach that can help acknowledge and empower women to feel more secure in their interactions with the healthcare system.

6. BIBLIOGRAPHY

- Aagard, M., Papadopoulos, I., & Biles, J. (2018). Exploring compassion in U.S. nurses: Results from an international research study. *Online Journal of Issues in Nursing*, 23(1).
- Ahlin, C., Hornsten, A., Coe, A., Lilja, M., Hajdarevic, S. (2018). Wishing to be perceived as a capable and resourceful person—A qualitative study of melanoma patients' experiences of the contact and interaction with healthcare professionals. *Journal of Clinical Nursing.* 28(7-8). 1223-1232.
- Altman, M., Oseguera, T., McLemore, M., Kantrowitz-Gordon, I., Franck, L., Lyndon, A. (2019). Information and power: Women of color's experiences interacting with health care providers in pregnancy and birth. *Social Science & Medicine*, 238, 1-9.
- Attanasio, L., Hardeman, R. (2019). Declined care and discrimination during the childbirth hospitalization. *Social Science & Medicine.* 232, 270-277.
- Alspach, J. (2017). Because Women's Lives Matter, We Need to Eliminate Gender Bias. *Critical Care Nurse.* 37(2), p. 10-18.
- Amundsen, S.; Øvebrø, T. G.; Amble, N.M.S.; Poole, A.C. & Nordeng, H. (2019). Risk perception, beliefs about medicines and medical adherence among pregnant and breastfeeding women with migraine: findings from a cross-sectional study in Norway. *BMJ Open.* 9(2). p. 1-9.
- Attree, M. (2001). Patients' and relatives' experiences and perspectives of 'Good' and 'Not so Good' quality care. *Journal of Advanced Nursing*, 33(4), 456–466.
- Bains, S.; Skråning, S.; Sundby, J.; Sørbye, I.K. & Lindskog, B. (2021). Challenges and barriers to optimal maternity care for recently migrated women – a mixed method study in Norway. *BMC Pregnancy and Childbirth.* 21 (686). p. 1-14.
- Bains, S.; Vanger, S.; Sundby, J.; Sørbye, I.K. & Lindskog, B. (2021). Newly arrived migrant women's experience of maternity health information: a face-to-face questionnaire study in Norway. *International Journal of Environmental Research and Public Health.* 18(14). p. 1-12.
- Barker, K. K. (2011). Listening to Lyrica: contested illnesses and pharmaceutical determinism. *Social Science & Medicine*, 73(6), 833-842**.**
- Beckman, L.J., Amaro, H. (1986). Personal and social difficulties faced by women and men entering alcoholism treatment. *J Stud Alcohol Drugs, 47*. 135–145.
- Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge*. Anchor books ed. Doubleday.

- Bevir, M. (1999). Foucault, Power and Institutions. *Political Studies.*XLVII. 345-359.
- Bloomfield, J., & Pegram, A. (2015). Care, compassion and communication. *Nursing Standard, 29*(25), 45–50.
- Bramley, L., & Matiti, M. (2014). How does it really feel to be in my shoes? Patients' experiences of compassion within nursing care and their perceptions of developing compassionate nurses. *Journal of Clinical Nursing, 23*(19–20), 2790–2799.
- Brown, B., Crawford, P., Gilbert, P., Gilbert, J., Gale, C. (2013). Practical compassions: Repertoires of practice and compassion talk in acute mental healthcare. *Sociology of Health & Illness, 36*(3), 383–399.
- Bryman, A. (2016). *Social Research Methods* (5th edition). Oxford University Press.
- Carli, L.L. (2001). Gender and social influence. *Journal of Social Issues, 57*, 725–741.
- Chamberlain, J., Watt, S., Mohide, P., Muggah, H., Trim, K., Bantebya Kyomuhendo, G. (2007). Women's perception of self-worth and access to health care. *International Journal of Gynecology and Obstetrics.* 98, 75–79
- Cherlin, E., Schulman-Green, D., McCorkle, R., Johnson-Hurzeler, R., & Bradley, E. (2004). Family Perceptions of Clinicians' Outstanding Practices in End-of-Life Care. *Journal of Palliative Care*, 20(2), 113-116.
- Courtenay, W. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, 50(10), 1385–1401.
- Courtenay, W. H. (1998). Better to die than cry? A longitudinal and constructionist study of masculinity and the health risk behavior of young American men [Doctoral dissertation]. University of California at Berkeley. Dissertation abstracts International, 59(08A), 232.
- Crowther, J., Wilson, K.C., Horton, S., & Lloyd-Williams, M. (2013). Compassion in healthcare – lessons from a qualitative study of the end of life care of people with dementia. *Journal of the Royal Society of Medicine*, 106(12), 492–497.
- Dahlgren, C., Stedal, K., Wisting, L. (2018). A systematic review of eating disorder prevalence in the Nordic countries: 1994–2016. *Nordic Psychology*. 70(3). 209-227.
- Darzi, L. (2008). High Quality Care for All: NHS Next Stage Review Final Report (No. 92). Department of Health.
- DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: a balance of relationship and rigour. *Family Medicine and Community Health,* 7(2).

- Dellenborg, L., Wikström, E., Erichsen, A. (2019). Factors that may promote the learning of person-centred care: an ethnographic study of an implementation programme for healthcare professionals in a medical emergency ward in Sweden. *Advances in Health Sciences Education.* 24. 353-381.
- Doohan, I., & Saveman, B.I. (2015). Need for compassion in prehospital and emergency care: A qualitative study on bus crash survivors' experiences. *International Emergency Nursing,* 23, 115–119.
- Evans, S., Villegas, V., Dowding, C., Druitt, M., O'Hara, R., Mikocka-Walus, A. (2022). Treatment use and satisfaction in Australian women with endometriosis: a mixed-methods study. *Internal Medicine Journal.* 52(12), 2096-2106.
- Fogarty, L. A., Curbow, B. A., Ingard, J. R., McDonnell, K., & Somerfield, M. R. (1999). Can 40 seconds of compassion reduce patient anxiety? *Journal of Clinical Oncology,* 17(1), 371-379.
- Foucault, M. (1979). Discipline and punish. London: Penguin.
- Freeman, E. (2019). Feminist Theory and Its Use in Qualitative Research in Education. Oxford Research Encyclopedias.
- Gil-Lacruz, M., Gil-Lacruz, A. (2010). Health Perception and Health Care Access: Sex Differences in Behaviors and Attitudes. *American Journal of Economics and Sociology*, 69 (2). 783-801.
- George, J. M. (2022). Compassion in Healthcare: Theoretical Perspectives. *International Journal of Health Sciences and Research,* 12(2), 340-348.
- Gona, C., DeMarco, R. (2014). The Context and Experience of Becoming HIV Infected for Zimbabwean Women: Unheard Voices Revealed. *Journal of the Association of Nurses in AIDS Care,* 26(1). 57-68.
- Gustafsson-Sendén, M., Eagly, A., & Sczesny, S. (2020). Of caring nurses and assertive police officers: Social role information overrides gender stereotypes in linguistic behavior. *Social Psychological and Personality Science*. 11. 743-751.
- Hadfield, R.; Mardon, H.; Barlow, D. & Kennedy, S. (1996). Delay in the diagnosis of endometriosis: a survey of women from the USA and the UK. *Human Reproduction.* 11 (4), p. 878-880.
- Hamberg, K. (2008). Gender bias in medicine. *Women's Health*. 4(3), p. 237–243.

- Hancock, B. H. (2018). Michel Foucault and the Problematics of Power: Theorizing DTCA and Medicalized Subjectivity. *The Journal of Medicine and Philosophy,* 43(4), 439–468.
- Hertler, C., Seiler, A., Gramatzki, D., Schettle, M., & Blum, D. (2020). Sex-specific and gender-specific aspects in patient-reported outcomes. *ESMO Open*, 5(4).
- Heyland, D. K., Cook, D. J., Rocker, G. M., Dodek, P. M., Kutsogiannis, D. J., Skrobik, Y., Cohen, S. R. (2010). Defining priorities for improving end-of-life care in Canada. *Canadian Medical Association Journal,* 182(16), 747-752.
- Heyland, D. K., Dodek, P., Rocker, G., Groll, D., Gafni, A., Pichora, D., Lam, M. (2006). What matters most in end-of-life care: perceptions of seriously ill patients and their family members. *Canadian Medical Association Journal,* 174(5), 627-633.
- Hoffmann, D. E., & Tarzian, A. J. (2001). The Girl Who Cried Pain: A Bias against Women in the Treatment of Pain. *Journal of Law, Medicine & Ethics*, 29(1), 13-27.
- Horsburgh, D., & Ross, J. (2013). Care and compassion: The experiences of newly qualified staff nurses. *Journal of Clinical Nursing,* 22(7–8), 1124–32.
- Jule, A. (2014). Gender Theory. In: Michalos, A.C. (eds) Encyclopedia of Quality of Life and Well-Being Research. Springer, Dordrecht.
- Juvrud, J. & Rennels, J. (2017). “I Don’t Need Help”: Gender Differences in how Gender Stereotypes Predict Help-Seeking. *Sex Roles.* 76, p. 27-39.
- Hansen, K. (2015). Ethnic discrimination and health: the relationship between experienced ethnic discrimination and multiple health domains in Norway's rural Sami population. *International Journal of Circumpolar Health.* 74(1). 1-12.
- Hansen, A. H., & Høye, A. (2015). Gender differences in the use of psychiatric outpatient specialist services in Tromsø, Norway are dependent on age: A population-based cross-sectional survey. *BMC Health Services Research*. 15, 477.
- Hill Collins, Patricia. (1990). *Black Feminist* (1st ed.) Hyman.
- Hill Collins, Patricia (1998). *Fighting Words - Black Women and the Search for Justice*. (1st ed.) University of Minnesota Press.
- Hill Collins, Patricia. (2006). *From Black Power to Hip Hop - Racism, Nationalism, and Feminism.* (1st ed.) Temple University Press.
- Hill Collins, Patricia. (2019). *Intersectionality as Critical Social Theory*. (1st ed) Duke University Press
- Hill Collins, Patricia & Bilge, Selma. (2020). *Intersectionality* (1st ed.) Polity Press.

- Husby, G., Haugen, R. , Moen, M. (2003). Diagnostic delay in women with pain and endometriosis. *Acta Obstetricia et Gynecologica Scandinavica.* 83(7). 649-653.
- Kawachi, I., & Berkman, L.F. (2001). Social ties and mental health. *Journal of Urban Health*, 78, 458–467.
- Kothari, A., Sriram, S. (2022). Voices of the Unheard: Women and Infertility in India. *Arena of Health.*
- Ladwig, K.-H., Marten-Mittag, B., Formanek, B., & Dammann, G. (2000). Gender Differences of Symptom Reporting and Medical Health Care Utilization in the German Population. *European Journal of Epidemiology,* 16(6), 511-518.
- Lien, I. (2021) Health workers and Sub-Saharan African women's understanding of equal access to healthcare in Norway. *Plos one*. 16(9). p. 1-17.
- Lindsay, S., Rezai, M., & Osten, V. (2019). Outcomes of gender-sensitivity educational interventions for healthcare providers: A systematic review. *Health Education Journal,* 78(8), 1-22.
- Lisspers, K., Larsson, K., Janson, C., Stallberg, B., Tsiligianni, I., Gutzwiller, F., Mezzi, K., Bjerregaard, B., Jorgensen, L., Johansson, G. (2019). Gender differences among Swedish COPD patients: results from the ARCTIC, a real-world retrospective cohort study. *npj Primary Care Respiratory Medicine.* 29 (45). 1-8.
- Loikas, D., Karlsson, L., Von Euler, M., Hallgren, K., Schenck-Gustafsson, K., Bastholm Rahmner, P. (2015). Does patient's sex influence treatment in primary care? Experiences and expressed knowledge among physicians – a qualitative study. *Family Practice*. 16:137, 1-9.
- Lown, B.A., Dunne, H., Muncer, S.J., & Chadwick, R. (2017). How important is compassionate healthcare to you? A comparison of the perceptions of people in the United States and Ireland. *Journal of Research in Nursing*, 22, 60–69.
- Lown, B.A., Rosen, J., & Marttila, J. (2011). An agenda for improving compassionate care: A survey shows about half of patients say such care is missing. *Health Affairs*, 30, 1772–1778.
- Macintyre, S. (1993). Gender differences in the perceptions of common cold symptoms. *Social Science & Medicine*, 36, 15–20.
- Madula, P., Kalembo, F., Yu, H., Kaminga, A. (2018). Healthcare provider-patient communication: a qualitative study of women's perceptions during childbirth. *Reproductive Health.* 15:135. 1-10.

- Malhotra, A., Vanneman, R., Kishor, S. (1995). Fertility, dimensions of patriarchy, and development in India. *Popul Dev Rev*, 21, 281–305.
- Maltseva,K. (2012). Normative culture, cultural competence and mental health in Sweden. *International Journal of Culture and Mental Health.* 7(2). 179-198.
- Mccaffrey, G., & Mcconnell, S. (2015). Compassion: A critical review of peer-reviewed nursing literature. *Journal of Clinical Nursing,* 24(19– 20), 3006–15.
- McDonagh, J. R., Elliott, T. B., Engelberg, R. A., Treece, P. D., Shannon, S. E., Rubenfeld, G. D., Curtis, J. R. (2004). Family satisfaction with family conferences about end-of-life care in the intensive care unit: Increased proportion of family speech is associated with increased satisfaction. *Critical Care Medicine,* 32(7), 1484-1488.
- Mello, S.; Tan, A.S.L.; Sanders-Jackson, A. & Bigman, C.A. (2019). Gender Stereotypes and Preconception Health: Men's and Women's Expectations of Responsibility and Intentions to Engage in Preventive Behaviors. *Maternal and Child Health Journal.* 23, p. 459-469.
- Mochache, V., Wanje, G., Nyagah, L., Lakhani, A., El-Busaidy, H., Temmerman, M., & Gichangi, P. (2020). Religious, socio-cultural norms and gender stereotypes influence uptake and utilization of maternal health services among the Digo community in Kwale, Kenya: a qualitative study. *Reproductive Health*, 17(71), 1-10.
- Møen, K.; Kumar, B.; Qureshi, S. & Diaz, E. (2017). Differences in cervical cancer screening between immigrants and non-immigrants in Norway: a primary healthcare register-based study. *European Journal of Cancer Prevention.* 26 (6), 521-527.
- Namasivayam, A., Osuorah, D., Syed, R., Antai, D. (2012). The role of gender inequities in women's access to reproductive health care: a population-level study of Namibia, Kenya, Nepal, and India. *International Journal of Women's Health.* 4. 351-364.
- Nasrabadi, A. N., Sabzevari, S., & Bonabi, T. N. (2015). Women Empowerment through Health Information Seeking: A Qualitative Study. *International Journal of Community Based Nursing & Midwifery*, 3(2), 105–115.
- Neff, K. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self-Identity*, 2(2), 85–101.
- Ng, N., Weinehall, L., & Öhman, A. (2007). 'If I don't smoke, I'm not a real man'—Indonesian teenage boys' views about smoking. *Health Education Research,* 22(6), 794–804.

- NHS Commissioning Board (2012). Compassion in practice: nursing, midwifery and care staff–our vision and strategy. Leeds, England: NHS Commissioning Board. Accessed on July 30th of 2023.
- Nunberg, G., Newman, E. (2000). The American heritage dictionary of the English language. Houghton Mifflin, New York.
- Oksuzyan, A., Danko, M.m Caputo, J., Jasilionis, D., Shkolnikov, V. (2019). Is the story about sensitive women and stoical men true? Gender differences in health after adjustment for reporting behavior. *Social Science & Medicine.* 228. 41-50.
- Osamor, P., Grady, C. (2016). Women's autonomy in health care decisionmaking in developing countries: a synthesis of the literature. *International Journal of Women's Health.* 8. 191-202.
- Paterson, R. (2011). Can we mandate compassion? Hastings Center Report, 41(2), 20–23.
- Pavlova, M., Weber, S., Simoes, E., Sokolov, A. Avenanti, A.(2014). Gender stereotype susceptibility. *PLoS ONE,* 9(12).
- Peters, M.A. (2006). Compassion: An Investigation into the Experience of Nursing Faculty. *International Journal for Human Caring,* 10(3), 38–46.
- Phelan, S., Burgess, D., Yeazel, M., Hellerstedt, W., Griffin, J., Van Ryn, M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity Reviews.* 16. 319-326.
- Pinkhasov, R., Wong, J., Kashanian, J., Lee, M., Samadi, D., Pinkhasov, M., Shabshig, R. (2010). *International Journal of Clinical Practice.* 64 (4). 475-487.
- Prather, C., Fuller, T., Jeffries, W., Marshall, K., Howell, A., Belyue-Umole, A., King, W. (2018). Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity. *Health Equity*. 2(1). 249-259.
- Puentes-Markidez, C. (1992). Women and Access to Health Care. *Social Science & Medicine.* 35(4). 619-626.
- Pylypa, J. (1988). Power and Bodily Practice: Applying the Work of Foucault to an Anthropology of the Body. *Arizona Anthropologist,* 13, 21-36.
- Pyo, J., Lee, W., Choi, E. Y., Jang, S. G., & Ock, M. (2023). Qualitative Research in Healthcare: Necessity and Characteristics. *Journal of Preventive Medicine and Public Health*, 56(1), 12-20.

- Riggs, J. S., Woodby, L. L., Burgio, K. L., Bailey, F. A., & Williams, B. R. (2014). “Don’t Get Weak in Your Compassion”: Bereaved Next of Kin’s Suggestions for Improving End-of-Life Care in Veterans Affairs Medical Centers. *Journal of the American Geriartrics Society,* 62(4), 642-648.
- Rodriguez, H. P., Rodday, A. M., Marshall, R. E., Nelson, K. L., Rogers, W. H., & Safran, D. G. (2008). Relation of patients’ experiences with individual physicians to malpractice risk. *International Journal for Quality in Health Care*, 20(1), 5–12.
- Rosenthal, L., Lobel, M. (2018). Gendered racism and the sexual and reproductive health of Black and Latina Women. *Ethnicity & Health.* 25(3). 367-392.
- Roter, D. L., Hall, J. A., & Katz, N. R. (1987). Relations Between Physicians’ Behaviors and Analogue Patients’ Satisfaction, Recall, and Impressions. *Medical Care,* 25(5), 437-451.
- Ruiz, M.T. & Verbrugge, L.M. (1997). A two-way view of gender bias in medicine. *Journal of Epidemiology and Community Health*. 51, p. 106-109.
- Sacks, T. (2017). Performing Black womanhood: a qualitative study of stereotypes and the healthcare encounter. *Critical Public Health.* 28(1). 59-69.
- Saltonstall, R. (1993). Healthy bodies, social bodies: Men’s and women’s concepts and practices of health in everyday life. *Social Science & Medicine*, 36(1), 7–14.
- Samulowitz, A., Gremyr, I., Eriksson, E., Hensing, G. (2018). “Brave Men” and “Emotional Women”: A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain. *Pain Research & Management.* 2018. 1-13.
- Schantz, M.L. (2007). Compassion: A concept analysis. *Nursing Forum (Auckland)*, 42(2), 48–55.
- Sinclair, S., Bouchal, S. R., Chochinov, H., Hagen, N., & McClement, S. (2012). Spiritual care: how to do it. *BMJ Supportive and Palliative Care*, 2(4), 319-327.
- Sinclair, S., McClement, S., Raffin-Bouchal, S., Hack, T.F., Hagen, N.A., McConnell, S, et al. (2016). Compassion in health care: An empirical model. *Journal of Pain Symptom Management,* 51(2), 193–203.
- Soler-Gonzalez, J., San-Martin, M., Delgado-Bolton, R., & Vivanco, L. (2017). Human connections and their roles in the occupational well-being of healthcare professionals: A study on loneliness and empathy. *Frontiers in Psychology*, 8:1475.

- Spandler, H., & Stickley, T. (2011). No hope without compassion: The importance of compassion in recovery-focused mental health services. *Journal of Mental Health*, 20(6), 555–566.
- Straiton, M & Myhre, S. (2017). Learning to navigate the healthcare system in a new country: a qualitative study. *Scandinavian Journal of Primary Health Care.* 35 (4). p. 352-359.
- Straiton, M.; Corbett, K.; Hollander, A. & Hauge, L.J. (2019). Outpatient mental healthcare service use among women with migrant background in Norway: a national register study. *BMC Health Services Research.* 19:944, p. 1-11.
- Strauss, C., Taylor, B.L., Gu, J., Kuyken, W., Baer, R., Jones, F., et al. (2016). What is compassion and how can we measure it? A review of definitions and measures. *Clinical Psychology Review,* 47, 15–27.
- Street Jr., R. (2002). Gender differences in health care provider–patient communication: are they due to style, stereotypes, or accommodation?. *Patient Education and Counseling*. 48. 201-206.
- Srivastava, A., Avan, B., Rajbangshi, P., Bhattacharyya, S. (2015). Determinants of women’s satisfaction with maternal health care: a review of literature from developing countries. *BMC Pregnancy & Childbirth.* 15:97. 1-12.
- Tait, R. C., Chibnall, J. T., & Kalauokalani, D. (2009). Provider judgments of patients in pain: seeking symptom certainty. *Pain Medicine,* 10(1), 11-34.
- Tenenbaum, A., Nordeman, L., Sunnerhagen, K.S., & Gunnarsson, R. (2017). Gender differences in care-seeking behavior and healthcare consumption immediately after whiplash trauma. *PLoS One*.
- Travis, C., Howerton, D., Szymanski, D. (2012). Risk, Uncertainty, and Gender Stereotypes in Healthcare Decisions. *Women & therapy.* 35. 207-220.
- Vaismoradi, M., Turune, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences*, 15(3), 398-405.
- Van Wijk, C., Van Vliet, K., Kolk, A. (1996). Gender perspectives and quality of care: towards appropriate and adequate health care for women. *Social Science & Medicine.* 43(5). 707-720.

- Vivino, B.L., Thompson, B.J., Hill, C.E., Ladany, N. (2009). Compassion in psychotherapy: The perspective of therapists nominated as compassionate. *Psychotherapy Research,* 19(2), 157–171.
- Vlassoff, C. (1994). Gender inequalities in health in the third world: Uncharted ground. *Social Science & Medicine,* 39, 1249–1259.
- Vlassoff, C. (2007). Gender Differences in Determinants and Consequences of Health and Illness. *Journal of Health, Population, and Nutrition, 25*(1), 47–61.
- Wallen, J., Waitzkin, H., Stoeckle, J. (2008). Physician Stereotypes about Female Health and Illness. *Women & Health.* 4(2). 135-146.
- Walsh, M. N; Jessup, M. & Lindenfeld, J. (2019). Women with heart failure: Unheard, untreated and understudied. *Journal of the American College of Cardiology*. 73:1, p. 40-43.
- Werner, A., & Malterud, K. (2003). It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors. *Social Science & Medicine, 57*(8), 1409-1419.
- West, C.P., Huschka, M.M., Novotny, P.J., Sloan, J.A., Kolars, J.C., Habermann, T.M., et al. (2006). Association of perceived medical errors with resident distress and empathy: A prospective longitudinal study. *JAMA*, 296(9), 1071–1078.
- White, M. D., & Marsh, E. E. (2006). Content Analysis: A Flexible Methodology. *Johns Hopkins University Press*, 55(1), 22-45.
- Young, K., Fischer, J., Kirkman, M. (2020). Partners instead of patients: Women negotiating power and knowledge within medical encounters for endometriosis. *Feminism & Psychology.* 30(1). 22-41.

7. APPENDIX A – INTERVIEW TRANSCRIPTIONS

INTERVIEW IMMIGRANT 01

R: So, I'm going to ask you some questions and then just feel free to answer. You don't have to tell me anything about like specific symptoms. I'm just interested in knowing about your perception. Like I don't need to know like your diseases or anything like that that you're not comfortable sharing. So I'm going to start talking a little bit about your knowledge of the healthcare system here in Norway. And the first thing I would like to know is, do you know how to properly seek out medical help in Norway?
IM01: I think it's a bit difficult to find where you're going to find specifics, for example. If you need like something that's very specific, you always have to go to your fastlege and not necessarily you're going to have what you need from there. And if you feel something, for example, that's something that I don't need to go to my fastlege, I can maybe try and go by myself and find the doctor. Then you can't go away. You can't do it. Or you have to go to the private doctor. That costs a hell of a lot of money. Yes. Very, very expensive, the private care here.
R: Have you ever had difficulties understanding how to properly use the medical services available?
IM01: A lot of times.
R: Could you talk a little more about that?
IM01: Well, it's very hard coming from a different country with a different style of medical services and trying to understand how everything works here.
R: Do you know what is available to you?
IM01: I'm still figuring it out.
R: You're still figuring out what's available to you. So you don't feel like the information that's out there is sufficient?
IM01: No, I don't know how the system works. And I've been living in Norway for almost five years now. And there's always something that's coming up. Oh, but you can do this. You can do this. You can do... There's a lot of things. I know that there's a lot of things that you can do online. But then you have to go and search or you have to ask someone. Because even when you go to the proper places, they don't give you information. They take for granted that you already know it. And I don't think the Norwegians know either. I think it's very hard to come by information about the medical services if you don't know what to ask. So you have to know exactly what to ask in order to be able to reach the medical service that you need. And not necessarily I know what to ask. That's why I am coming to ask for help. But if I don't know what to ask, you know. Like, for example, if you work in a health care system, you know how the health care works. So it wouldn't be easier to give like tips. You can do this, this and this. But if I don't come with the made question, the proper question, it's like, but you didn't ask me this. Yeah, maybe I didn't know. But you knew. Couldn't you say? But then you have this option also.
R: So you feel that the medical personnel is not forthcoming with information as well.
IM01: No. Even though they might know something that can help. And give a lot of unnecessary information. Instead of providing you with information that you actually need, they just give you information that is somewhat useless.
R: Do you know which health care systems are available and how to reach them?
IM01: Yeah, I think after a lot of struggles and a lot of dead ends now I understand a little more.
R: So now I'm going to talk a little bit about how you seek out medical care and everything. How long after presenting symptoms do you usually seek out medical care?

IM01: In the beginning, I would do it right in the beginning. Like, okay, I have started feeling this and this and this. And I'm going to try to find help. But after Corona, I try to wait and see if I'm going to get better by myself. Because that's what I feel. That if you go right in the beginning, when you start feeling symptoms, it's like, okay, but your body is going to fight by itself. Go and take a paracetamol. And go home and relax. So if I don't get better within some days, then I go and search for help.
R: So you always wait a few days and that only started after Corona?
IM01: Mostly after Corona. Because they were like, okay, you shouldn't come if you're sick and blah, blah, blah. And all the tests. If I don't really have to go, I would rather not go in. Because it's so much trouble to get things. So the hassle to get medical care is not worth it. It's too much problems to get it.
R: And do you find it easy to seek out medical care here in Kristiansand?
IM01: No. I've been trying to reach my fastlege for days now. They never take the telephone. You have to go there to see if you manage to get the consultation. If you go online, they say, okay, you can order at that time, but it's in two weeks. So if you need an emergency or something else, you should try to call the doctor's office. But they never take the phone.
R: So you think that there's a lot of difficulty trying to reach your doctor?
IM01: Yes, if you get a letter from the hospital. And then you don't know if they call you, you don't know who is calling you. I had this surgery in October and I always get a call from the hospital. And I would try to call them back, but I was just calling the number that they had called me. But I couldn't reach. Like, okay, I was using 20 minutes. I had to go from work and ask, can I call them back to see what's going on there? Because you never know. You just never know what's happening with your own medical situation. Even though you should be very aware.
R: Is there any external factor that can prevent you from seeking medical care when you're in need of it? Like, I don't know, money or someone that prevents you from going to the doctor or work won't allow you to take time off to go to the doctor or anything?
IM01: No, about this, it's completely okay. That part is very good here and everything.
R: Okay, so now we're going to talk a little bit about your relationship with your fast leg. First of all, I would like to know if your fast lege is a man or a woman or non-binary.
IM01: My fastlege is a man.
R: So you have a male fastlege. And do you trust your fastlege?
IM01: Yeah. He's from my country.
R: So the reason that you trust your fast leg is because you have a shared background.
IM01: Yeah, and we can talk the same language, so I feel more comfortable.
R: Has he always been your fastlege?
IM01: No.
R: And your previous fastlege, did you also trust him?
IM01: I was only one time there. It was like right after I had gotten my visa, I had this fastlege, but I figured that there was another one that was from the same country as me, so I changed.
R: Yeah, that's fair enough. And do you feel comfortable sharing any type of information that could affect your health and subsequent treatment with your fastlege?
IM01: Yeah, I do.
R: And do you feel heard by your fast leg?
IM01: Not necessarily.
R: So even though you trust him, you don't feel like he hears you?
IM01: Yeah, I think it's a bit cultural. Like, okay, we're going to try this treatment, or the treatment is, you just go and change your diet. You do like this, like, let's follow what the system here tells you to do. But not necessarily is what I'm searching. Like when you're sick for months and you ask, hey, can we check this a little bit further? And if you feel worse, then

you can go to the doctor. Okay, then I wait. So you feel that he just keeps pushing and pushing? Let's give your body the chance of fighting back. So he just waits for things to kind of happen instead of being... If it doesn't, if you don't get better, then you come to me.
R: Yeah. Well, that's not the best. Is there anything that you would like to change regarding your relationship with your fastlege yet?
IM01: I don't think there's much to change. Like, I lost my hopes.
R: So you do think that there are things that you would like to change, you just don't expect that you'll be able to have those changes?
IM01: Yes, because I don't think everything is under his control. Yeah. Like, he might want to do more, but if the system comes in the middle, you are not really allowed to do it, then he has his hand tied. So I don't know which point is the system not giving you opportunity, which point is you think that's unnecessary.
R: Okay. You would like to change some things, you're just not sure if it's possible to change them.
IM01: Yes.
R: And if you could change, what would you change?
IM01: I think more preventive medicine. Like, if you are feeling something, then you can come and say, hey, I'm feeling this, this and this, and can you go and check it? Without having these excuses. Like, oh, but you can go and lose weight or change your diet and see if it works. Like, I'm reacting to either milk or gluten. Yeah, but why don't you try to stay one month without eating gluten and one month without eating milk? Yeah, but do you have a test that you can take? So instead of actually using the tools available, he just kind of wants you to... Go and test by yourself.
R: Okay. So you feel like a lot of the medical care that you have, it's you doing it and not the actual doctor or the system doing it.
IM01: Yes,iIf I see that my body is reacting to something and you have the tools to figure out what it is, why should I go through the trouble of testing something that I don't really know what it is? If you can just go and take my blood sample and test.
R: You feel like the system here doesn't properly utilize all the tools available for people.
IM01: Exactly.
R: You feel like they just kind of are very reactive and kind of wait and see and let people kind of figure it out on their own.
IM01: Exactly.
R: So do you think that people are too responsible for their own medical care here in Norway?
IM01: Yes.
R: And you think that the doctor should have more responsibility?
IM01: I think if you can't prevent something, it's much better than you have to take an action after things have actually happened. And I do feel that many people here, they wait until the situation is way too bad to take an action because they don't want to go. They think that it’s not worth going to the doctor, if you are feeling pain you're going to get a paracetamol. Then I don't go to the doctor because I can take paracetamol at home.
R: So you feel like people avoid seeking medical care here because they just feel like it won't have an impact.
IM01: Yes, because they don’t see the point in wasting time just to be given paracetamol.
R: Do you think it's worse for women or do you think it's the same?
IM01: My experience is that it's pretty much the same.
R: So you don't think there's a difference there between the treatment received by men and women?
IM01: Not that I have seen. It's bad for both.
R: And do you believe that the medical treatment you receive is adequate to your needs?

IM01: No.
R: Why is it not adequate? Why do you think that?
IM01: I would like to feel that it's easier to go to a doctor that's like a specialist. Because I don't really know that if my first leg is equipped to solve all the problems alone. Like he can do just this because he is not a specialist. He's not a specialist in allergies, he's not a specialist in gynecology. He does like... He puts the fire out. He doesn't actually fix the things that are wrong with me.
R: So you feel that he just kind of puts a band-aid on problems.
IM01: Yes, but it's not his problem that it takes so long time for you to get a specific doctor, who actually can examine you and see which needs do you have. So, since it takes so long this waiting time, if I'm feeling something now and go to the doctor and say I think I need to go to a specialist for allergy because I've been sick all the time. Okay, I'm going to send you to the specialist. Then it's going to take six months. And like, what's the point of you waiting six months?
R: So you think the time that it takes to be able to go to a specialist is a problem to your needs?
IM01: Yes.
R: And you would like to be able to reach out to the specialist easier? You think it's too complicated to reach them?
IM01: Yes. And either it's okay, then waiting six months... ...either you're going to be better or you're going to be worse. So either your body gets better by itself or you're in a much worse condition because it takes so long. Yes, it's too extreme.
R: And then in your perspective, how does the healthcare system affect your everyday life?
IM01: I feel that makes me feel insecure about living a proper life when you know that you are not going to have proper healthcare. I get terrified of getting sick because if I get sick I cannot go to work. And I don't have a fast job. So if I miss too much work, they can just say they're not going to renew your contract because you get too much sick. You get too much sick.
R: So you feel like it creates an aura of insecurity to your everyday life.
IM01: Yes. Because you don't get things solved in time or properly solved. So it takes a long time to solve things instead of fixing them properly the first time. And it goes to the time that it takes to go to the specialist, to get an appointment with the fastlege. Everything takes too long.
R: So, you feel that instead of problems being solved faster and properly, you're always having them reoccurring.
IM01: Yes. Because they're not properly treated to begin with, they always come back after a little while. It feels like you always get a bandaid solution and never actually treated.
R: Is there anything that's not medical related that prevents you from seeking healthcare when you are in need?
IM01: No. I don't think that there's anything like that that affects me.
R: Do you believe that being an immigrant has impacted your medical care in any way?
IM01: I don't know because I can't compare. I don't have Norwegian friends who I can seek and ask. But it might be, considering that the Norwegians know the system. They have more knowledge because they grew up here.
R: Have you ever felt that your fastlege or the people at your fastlege or at the hospital have treated you differently? Because you're an immigrant. Because you don't necessarily speak the language, don't know the system as well.
IM01: I have experienced it once in my fastlege. I was talking and they were asking about my personal number. And then I started talking in English, I think it was something like that. And then they started speaking Norwegian and said to me, you have to learn it. So there's a pressure for you to learn it, to be able to be properly treated. And I feel that when I spoke only English with them, they had this way of treating you. And they respect you a lot more if you speak with

them in Norwegian. Which I don't feel that this should happen. And that's the reason why I have my fastlege from my own country. Because I feel that it's easier for me to explain what I'm feeling. And maybe to come to him and search for help. This thing here, I don't understand. Can you help me with this?
R: Are you aware that you can request a translator for your medical interactions?
IM01: No, I didn't know that. That was never explained to me.
R: So the fact that you're fastlege is from the same country has helped a lot.
IM01: Yes, because I can come to him and say, hey, I went to this doctor. And I kind of understood maybe 70% of what he was telling me. But do you have any better knowledge? Can you see the journals and see what he wrote there and explain it to me a bit better? Because even though I speak Norwegian, medical language is a very difficult language. So I don't feel that I should know it. That I'm not going to medical school. So that's very difficult for me to explain things. Or maybe to understand. And about this, I think I am lucky. Because I can speak my own language with my doctor. But I don't wish to change. Only because I don't feel that maybe I'll have the same treatment. The same understanding if I change to another Norwegian doctor.
R: So you think a Norwegian doctor wouldn't treat you the same?
IM01: I don't think so.
R: Why do you think that?
IM01: Well, I just feel that there not a willingness from Norwegian doctors to try and communicate with you in English if needed, so it just makes everything harder.
R: Have you ever felt discriminated based on your immigrant background?
IM01: No, aside from the difficulty in them talking to me in English, I never felt discriminated due to being an immigrant.
R: Alright, those were the questions I had. Is there anything else you want to talk about? Your experience or how you feel about medical treatment? From your perspective, from your experience this year. That you think is important?
IM01: Nothing that I can think of.
R: Alright, thank you very much.

INTERVIEW IMMIGRANT 02:

R: Okay, so it's recording, so immigrant 2, just so I know who it is. So we're just going to talk a little bit about the healthcare system here and how do you feel about it. And the first thing is, do you know how to properly seek out medical help?
IM02: Yes, I do. I think it's a little bit difficult to book appointments, but I do.
R: why do you think it's difficult to book appointments?
IM02: I just think that if you don't have some type of emergency happening, it can take a long time to get an appointment.
R: And have you ever had any difficulties understanding how to properly use the medical services?
IM02: Yes, in the beginning it was a lack of understanding how the system works, what is your doctor, practitioner who you would call or book appointments. I didn't know much. And I was dependent on my husband, and he was not so into doctors, so he was not interested. I think I had to find myself on groups on Facebook to find out how the system works. It took a little bit of time.
R: You didn't know where to go to find it?
IM02: I had no information, but I got a letter in my mail, so it came, with very little information about how to use the system, just who my fastlege was and the contact information. It took a little bit of time, but eventually I started learning a little more about how to use the system.

R: And how did you feel about that, not knowing where to go to look for things and how to go about it?
IM02: Lost. I felt myself completely dependent on my husband. It's not a good feeling, I think. I think that's it. I felt myself lost and complaining a lot about that. Just consulting my friends and doctors in Brazil and trying to do a bridge between what was my doubt and how could I find out a similar treatment in Norway. So it took quite a time to realize how it works.
R: Do you know which health care systems are available now and how to reach them?
IM02: Now I know. Now I know where they are, how to find them. Maybe it's a little bit of my profession. It has helped a lot to find out, but it's still difficult to be in specialists in Norway or to see them. I know where they are, but it's difficult to reach or approach or be referred for treatment there with the specialists.
R: So for you, going to the normal doctor is okay, but going to a specialist is still a bit more complicated?
IM02: At a certain point it is okay, but we have a little bit difficult to book time with the doctors now because they don't have a place, they have a lot to do, they are overwhelmed, they cannot give you such a close date, so you have to wait a little bit.
R: The specialists or the fastlege?
IM02: Both. Yeah, both of them. Both of them, because it's basically also, if you get an appointment with a specialist, it maybe takes six months, depending on how serious the problem is, it can take time. So like simple things. Simple things, it's more difficult. Maybe if you have some acute problems, emergency, maybe you find a way to be with a specialist faster. Yeah. This is how I feel. And it's natural as an immigrant to compare with your own country, the experiences you had before, so I'm usually comparing all the time because in Brazil it's a little bit easier to get a contact specialist and here it's much more difficult. But you get it. You get it, it just takes longer.
R: And how does that make you feel, that taking time to see a specialist whenever you feel like you might need it?
IM02: I feel awful, because now I'm also in the process of aging and I feel like I need a lot of specialist's opinions and I don't get to them. I just don't get to them.
R: You don't get to them because your fastlege doesn't refer you?
IM02: Yeah. Yeah. So there's like a gatekeeping that the fastlege does that... They don't feel that it's necessary because I don't have actually a problem.
R: So there's no preventive treatment you think?
IM02: It's difficult. Yeah, so they kind of wait for things to happen before taking a step. They hope that you behave like the Norwegians. In Norway they grow up with a certain system. They are used to it. Maybe good food or exercises, but when you move to another country you had experiences that was different from before and maybe it doesn't fit, you know, your lifestyle. And so maybe you need a little bit of understanding, but then you don't find it because it takes time and they don't believe it, you have a problem. And then it just takes time. They don't send you to a specialist just because you want to know if you have something. You have to have concrete symptoms before you are able to see a specialist.
R: So they only send you to a specialist if you're already sick?
IM02: Yeah. They don't send it if you just need to be checked. Usually. Yeah.
R: And a little bit about how you go about seeking healthcare. How long after presenting symptoms do you usually seek out medical care? Do you go right away? Do you wait?
IM02: Usually I go right away if they have time available. Available time, so I go right away.
R: And then if they don't have time?
IM02: I just have to wait.
R: But as soon as you present symptoms you start looking for ways to go to your fastlege?
IM02: I start looking for it.

R: And how do you feel having to wait to be able to see your doctor?
IM02: Really scared actually, because I feel sick and I'm trying to see my fastlege to see whats wrong with me, but it just takes so long sometimes.
R: And do you think that it's easy to seek out medical care?
IM02: As I said, it's not difficult because you find everything online. You can just book online. It's quite easy to do it if you feel comfortable with social media or computers. So it's very easy to do that. But they don't have time available. The schedule is very busy. Yeah. There's maybe a staffing issue. So if you're not going to an emergency care, you have to wait maybe two, three weeks before you get an appointment with symptoms or not. And sometimes they try to solve the problem by the phone and I don't like it.
R: Why don't you like it?
IM02: Because I like to be in presence. I like the physical approaches. You like to see me. To properly examine you in person.
R: So you feel more comfortable when you're able to be there in person.
IM02: Yes, it was very difficult in pandemic time. We could not be there if you were sick. And that just made me very anxious. Because I just wasn't sure what to do if something that was not Covid happened.
R: So during the pandemic you felt that the services available were harder to reach?
IM02: Yes and it was not a good feeling.
R: Is there anything like an external factor that can prevent you from seeking medical care if you're in need of it? Like it's too hard or it's time-consuming or money-wise, anything?
IM02: Money, maybe. Because you have to pay a bit of it. Yes. So maybe money and the economic situation to where you are can stop you from looking for it. Yeah. And the time you have to wait. It's consuming. The time you have to try again and call to the health stations and they work in a very small amount of time in a day. And you are at the job maybe, you don't have time to stop and call them. And I think it's a barrier. Yeah. So like the amount of time that you have available. You need to talk to them if it's something that you can't solve in the internet with your own booking.
R: And talking a little bit about your relationship with your fastlege, first of all, if you feel comfortable telling me, is your fastlege a man or a woman?
IM02: A man.
R: And do you trust him?
IM02: To a certain point. But I think he is a part of the system already. I trust him because it's easier to communicate to a certain point. I believe that I can trust him. But in the same way, he is showing me that his behavior is just like the system here. He needs to solve the problems himself before he sends me to a specialist. But I trust him.
R: You trust him but there is a limit to what he can do for you.
IM02: Yeah. It's because of the system. He is close with the system. You can't do much.
R: So it's not that you don't trust him but there is a limitation on him because of how the system is.
IM02: Yeah. And that's something that, That's just the way the health system works in Norway. They have a lot of rules that you have to obey. You can't just go further because you think it's right. You have to obey the system, the scales that you use here.
R: So there is a lot of bureaucracy. Barriers. And what do you think about that?
IM02: It sucks.
R: Does it make you feel... Not heard?
IM02: Yeah. That means my symptoms doesn't mean so much if I am not really showing a big problem. It's just like I am not heard. They don't hear what I want. Yeah. They just want to follow their rules, but don't want to hear my opinion about my situation.
R: Do you feel heard by your fastlege?

IM02: Not always. Not always.
R: You think there is a limit to what he hears you?
IM02: Yeah. I have an overweight problem. And it always comes to that point that the problem starts with the overweight. So he just refers that everything is related to your weight without looking at other options. Yeah. So I have to work by myself about it. Because in Norway, for example, it's difficult to find a nutritionist specialist. You don't have it unless you have a symptom, a disease that needs a nutrition practitioner. So you don't see them unless you are in a hospital. You will not see them. Yeah. And I was used to have one in Brazil. I had to import always a nutritionist care from my own country. But they don't know the life in Norway. They don't know what I can eat. It's a lot of work that I have to explain much more. It's a double work.
R: And do you feel comfortable sharing any type of information that could maybe affect your health and treatment with your fastlege?
IM02: No.
R: You don't feel comfortable sharing anything?
IM02: No, I feel comfortable sharing. I don't have a problem to share with him.
IM02: You just don't feel that he hears you as much?
IM02: Yeah. I feel a bit dismissed by him sometimes. Always will stop by a weight problem. Yeah. I know it is obesity. It is a part of a disease according to the World Health Administration. But I think there is a little bit also to investigate. They don't investigate. So it kind of goes back a little. There is no preventive care. They only seek out and investigate after something already happened. Yeah. After something serious already happened. And if you have mild symptoms., they don’t look into it. The best experience I had in Norway was when I had a fracture in my arm. In that point I saw a specialist at the hospital. I had very good treatment care and I was heard at a certain point. But when it comes back to the preventive part. That is a little bit difficult again. But in the specialist... When you can reach the specialist when you are there... When you finally get to the specialist. When you finally get there, then you have a very good treatment. I can't complain.
R: So you just think there is a barrier to get to the specialist.
IM02: Yes, but this is the way they have the financial system. This is the way they have structured the financial part of the system. If everyone could reach the specialist, they just don’t have the structure for that.
R: Is there anything you would like to change about your relationship with your fastlege?
IM02: There are. Yes. I think he could listen to me. And try to give me feedback. Because I don't feel I get the feedback. A consult starts and I am with the doctor. I tell him that I need something at a certain point. He can provide me some kind of simple care. But then I don't have a feedback. It's just the first consult. So I go to maybe blood treatment or x-ray. But it goes. It comes no answer. They never tell you. How it is. It is good. It is not good. You don't see the exams.
R: You would like to be able to have more information about your own health information?
IM02: Yes, either way if I am sick or not sick I would like to see those results. And if I want to see those I have to pay for it. An extra fee that I already had paid. This I would like to change.
R: So you would like to have more information about your own health.
IM02: More feedback. And more information. I would like to have more information about my own health. More information about your own health. I feel like everything I have to ask. I have to show a way.
R: So they are not forthcoming with information.
IM02: No, they’re not.
R: How does that make you feel?

IM 02: The fact that there is no forthcoming of information towards you. You always have to be the one. It's a double work. Maybe that's my role in Norway. I have to see what is the best treatment in one situation. And then I have to tell them. This is the treatment I want. And they will see that maybe I can get it here. But it's always a barrier. It's always my duty to find the treatment. And I am not used to it. I think they are the specialists. They have to show me. You have this way and that way. Maybe they do that if you are really sick. You have cancer or something serious. Mental health for example. I think it's more difficult to find out if you have something or not. Because you never have the feedback.
R: So you just feel like you are too in charge of your own treatment. And that they don't provide you enough information to make good decisions.
IM02: I think it's communication that is a little bit difficult. They have a lot of privacy policies in the health system. They cannot communicate with each other so easily. And it comes back to the patient. It happens again. Maybe many other women feel like I feel. But I feel like I don't have the feedback of my health. If it's ok, I don't hear anything from them. Or what do you want to do about it? For example, you see that you are not sick. What can we do about it? Are you still feeling the way you feel? If you feel that you are at a certain point that brings you here. And nothing is done. You just stop with that first consult. This is how I feel. I don't feel treated or heard.
R: A little bit about how it impacts your everyday life. Do you believe that the medical treatment you receive is adequate to your needs here?
IM02: No. Not even a little bit.
R: Why not?
IM02: Like I said, I don't get enough information. I don't see the exams. It's difficult to go to a specialist if I want to. I always have to talk to the practitioner. Before I can get one. Even if I have economic conditions to pay for a private. I don't even know where it is. A private service in Norway. And what kind of services do they have? Or maybe the system will also stop them to do something. Because maybe I will have to go through all the steps that you have to go through. To come to a certain point.
R: Do you feel in a way that the system is a bit too rigid?
IM02: It's like a four-sided box. They don't go out of it. There's no other choice. There's a lack of humanity in a sense. They don't understand that people are individuals. Especially if you come from another country. It's difficult for them to understand it. That there's a difference. In your perspective.
R: and how does the healthcare system affect your everyday life?
IM02: A lot. It affects my self-esteem sometimes. And causes me to be anxious. Because I don't know, am I healthy enough? Are they telling me the truth? Because as I said, I don't see any results of the exams. So it creates a sense of insecurity to you. So you feel very insecure about things.
R: Is there anything that's not medical related that prevents you from seeking medical care? You mentioned a little bit money.
IM02: Yeah, maybe. Money or time. Yeah, money and time. I know that if you are a regular worker, you can stop your job and go and visit a doctor. But sometimes it's not that easy. Because of the distance, for example. If you live in Mandal, you don't have a clinic where you can take x-rays. You have to drive one hour before you can get one. You understand? So I think it's a lot of barriers. Maybe the distance is one of them. There are a lot of small cities where they don't have an specialised centre or clinic. And you have to drive to a much bigger city to get it.
R: Now talking about your experience as an immigrant. Do you think that being an immigrant has impacted your medical treatment in any way?
Im02: Yeah.

R: In which ways do you think it has impacted?
IM02: As being an immigrant, in the beginning when you don't have enough information, it causes you anxieties. I had many panic attacks in the beginning. And maybe because you don't know how it works. And depending on where you live, in the law they say that you have a right for a translator. Yeah. But it doesn't work as in the law. Sometimes you don't get it. I didn't get it. My first time with a doctor, he was not Brazilian at that time. I had another doctor, you know, it's something you can change. The fastlege if you need. And in the beginning I had one that was Norwegian. Communication in English was ok. But I would prefer to have a translator with me. And they didn't have one available. Because it was a small town. You see, I think it creates a lot of misunderstandings, maybe. And then you don't get the treatment that you really wanted. Or you were there because you could not explain what you wanted. In a certain way it caused me, it impacted me negatively.
R: And have you ever felt discriminated based on your immigrant background?
IM02: No. Because I didn't have so much experience of health problems in Norway. And the only time I've been in a hospital, so I was well treated. And maybe with the first practitioner, some was Norwegian and was a little bit of... There was more of a communication barrier. But I don't feel discriminated.
R: That's good. Is there anything else you want to talk about? Like how you feel about the medical care here? Any comments or anything?
IM02: I feel If you have kids in Norway, you have much better treatments than when you come here as an adult person. And maybe they could just do the same thing they do when they protect the kids so much. And have a good system that takes care of all the family. And it's not just to treat the problem, they treat all, they surround that family with care. But when you are an adult, you don't even need to follow a rule of a doctor if you don't want to. And I think this is weird. I cannot, for example, access to my daughter's medical reports. I cannot get any information after she is 16 or 18, I don't remember. I cannot know anything about her. If she is sick, if she is not sick. If she is 16 and has an abortion. I don't even have the right to know if she doesn't want to.
R: So you would like that to be for everyone? You would like to have more transparency?
IM02: They have a station where you go there and they have all kinds of specialties for kids. But when it comes to adults, it's much more decentralized. I think it's difficult to find... I don't feel in the same way. Maybe when you become older, it gets better.
R: So you would just like to have a bit more transparency regarding your data?
IM02: Yes and what they do doesn't fit with what they say. The law, for example, says that you have to have all your medical assistants in a digital platform where you could access yourself. I don't have anything registered there. If I go into a health center or log in on that platform, I don't read anything because there's nothing that is registered. They say that it will be, but it's just not there. So the transparency goes and I don't feel surrounded by healthcare at all. Maybe if I fake symptoms, then comes something. This is just the way I feel.

INTERVIEW IMMIGRANT 03:
R: This is interview with the immigrant woman number three. Where are you from?
IM03: Mexico.
R: I'm just gonna talk a little bit of how much do you know about the health care system here in Norway? Do you know like what are the channels that you can use to properly seek out medical care?
IM03: I know that I have a doctor and I received a letter. I got my personal number then it said this is your doctor. But I could not make an appointment because I didn't have bankID yet, so I had to use the phone in the beginning.
R: so are you still using the phone to contact him or do you know if there's any other way?
IM03: I just go directly you just go directly because they don't yeah, sometimes they don't answer the phone then I just go.
R: And have you ever had difficulties understanding how to properly use the medical system the medical services here?
IM03: I still don't know how it works. But I just go there and I just ask like just go and you hope for the best yeah, they can help me or like I sometimes I have the phone I call and I tell them like I have this that that and then they tell me come to this hour
R: So you don't know how to book appointments by yourself without using the phone?
IM03: now I know because I got like information from friends on how to do it. But it's like there's never an appointment. So what's the purpose then? Then I just directly
R: you just go directly because It's easier?
IM03: Yes, because if I go to the system there's no availability. There's nothing like sometimes like there's like okay one month or two months but by then I'm okay.
R: And how do you feel with that amount of time that it takes to book an appointment sometimes?
IM03: Well, like I tell you I don't Really have that patience. So if I'm sick, I need some people to hear about my sickness and I need some help. I just go and I stay there until they can see me.
R: so you just sit at the doctor's office and you wait for them to manage to fit you in?
IM03: Yes. I know it's a waste of time but don't care. If I'm sick, I rather wait at the doctor's office a few hours than try to book an appointment a month away.
R: Do you know which health care systems are available and how to reach them? For example, when to go to the fastlege or to the emergency?
IM03: Now I kinda know how it works. For example now, I know like if it's nothing serious then you go to the doctor normal doctor make an appointment and wait for your month and If it's something like it really needs attention, then you go to legevakt. It was the first time my son had some injury and then the fastlege was closed, so I went directly to the legevakt. but nobody explained to me how it works.
R: So, no told you where you could go to or how to use the emergency?
IM03: No, because then when I arrived they told me no you need to call first. Yeah, I was like nobody told me that I need to call first. I'm just here because my son has his hand burned. I need attention.
R: So nobody ever given you any type of information of how to use it and or even where you can find that information?
IM03: oh, no, nobody.
R: And what do you think about that?
IM03: I think it's very frustrating, especially for immigrants with kids. They're kids, sometimes unexpected things happen and you can't wait until the doctor is open in two days. So it's important to know how to find help.
R: How long after you present symptoms do you usually seek out medical care?
IM03: I wait a lot of time.

R: Why do you wait a lot?
IM03: Because I don't wanna waste my time. I don’t want to just sit in the doctor’s office and wait, so I only seek out help after a long time.
R: So you wait a lot of time to seek medical care because you think it takes too long time to receive care?
IM03: Yes.
R: So if it was more available, you might seek out more? Or quicker?
IM03: Yes, but it's it takes a long time and it's just like it discourages you from seeking, you know, it doesn't encourage me. So I just wait until I'm really like really bad and then I go.
R: And do you find it easy to seek out medical care here?
IM03: It's easy if you call and tell that it’s serious. Then they tell you yeah, you can come or you can wait a little longer. It's like a very difficult question for me because they do help but it's not so much of a help. That's why I don't go anymore. It's like just take your paracetamol .Like I just don't go anymore because you just don't feel like it solves your issues. Because they don't know why this is going on and then like I had to call I called Emergency number once so the ambulance came to my house two weeks ago. So that was and I said there's no need for an ambulance and they're like, yeah but you cannot come alone with those symptoms. You cannot come to the to the doctor. Yeah, and I'm like this is something like I don't think it needs an ambulance. I had chest pains, but I thought it was muscular, so I just wanted to check, just in case and they're like no then you should just call the ambulance. So the ambulance came to my house and brought me to the hospital. They checked me and tI had some different heartbeat, but they still they're like, we don't know why and I'm like, so What can I do?
R: And they didn’t tell you what you should do to find out more or anything?
IM03: No, it was just like, we don’t know why, but you’re fine now, so you can go home.
R: So, do you feel like You don't receive enough feedback about your health here?
IM03: No, and then they make you do tests and they're like, oh we made some tests and you're fine. Can I see those tests? Can I have like some kind of paper? Yeah that the tests are okay I just have to trust whatever they say. Okay, I'm okay but can I just have this test just to like check with my doctor in Mexico or to just know.
R: So you feel like there's no transparency with your own medical history?
IM03: Yeah, why can’t I just see the results of the tests?
R: And how does it make you feel the fact that you don't have any control over your own information?
IM03: It feels weird. I don't know like it feels like I don't have anything. I don't have control over whatever information there is about me. I don't know. Yeah, so It feels it feels weird. Yeah, it's different like where can I seek this information? And perhaps it will be easier if they just put it online like in the same system that you can see I don't know or like just send you an email like this is the results of the exam
R: Did you know you can pay for some exams? Do you know you can pay to receive the tests? Not all exams, but there are some that you can pay and then you receive the test.
IM03: No, I didn’t know that.
So I told them I don't want to go to the hospital because I know it's only muscular pain so I went there the ambulance and everything was nice it was nice that they took care of me, but I didn't need this and it was unnecessary. Then I go there and they check in the heart is fine. It's only muscular. I was telling them. It's only muscular, they discarded that it was a heart problem. But then all these resources were wasted on me, when I knew it was nothing severe and told them that and then at the end of the day, I don't have any any solution to my problem.
R: Do you feel like the medical personnel is forthcoming and gives you enough information?

IM03: They're really nice. Yeah, they're like very helpful. Like we're gonna do this. We're gonna give you this medicine We're gonna so they explain things very well for you so you can make good informed decisions. They told me everything
R: And you mentioned you didn't choose your doctor, right? You got a doctor appointed to you. Would you be comfortable saying if it's a man or a woman?
IM03: Yes, it's a woman.
R: Do you trust her?
IM03: Yes.
R: Do you feel comfortable sharing any type of information that can affect your treatment with her?
IM03: Yes.
R: Do you feel like she hears your concerns and everything?
IM03: Yeah, she hears me. Still there's like it's a they hear me, but it's not any solution.
R: Yeah, so they hear you but they somewhat dismiss your concerns?
IM03: Yeah, it's like well, we don't know what to do. Like they just don't investigate your problem. There's no preventive or there's no proactiveness in it. It's like you just go say the problem they listen and they are like, okay, and then they're like, well you can take this thing but if the problem persists it's still there and you don't know what is being done if they're doing anything, because they are they're not giving you any feedback. They just like oh everything's fine. But how do you see that?
R: So the he fact that there's no feedback for your own health is something that makes you feel negatively affect? How does it make you feel?
IM03: Well, I feel like it's a little bit like I don't think this is people care. Is like they're waiting you almost like to be dying to do something about it. Like they if they see you're okay, like you're talking and you're moving then it's not necessary to do anything. So unless it's something very serious I don't think that they take it seriously enough. They just treat it like it's not a problem. So then that's why I don't go anymore. Like I just like try to do things on my own
R: So you try to kind of fix yourself as much you can? Be your own doctor?
IM03: Yes.
R: So you don't rely on the medical system here as much anymore because you just don't feel like it's it's there for you?
IM03: It's because they're like I told you like there for the ambulance and they they're like exaggerate a little bit if you if you tell them this is the problem. But I just need an appointment. Then I was thinking to myself. I should not say the problem I should just say I want an appointment and then at appointment I tell the problem. But I have gone through this like several times and I tell them I get like heart pain yeah, and I get the arm pain here because after the vaccine was a problem. So then I have this pain and then the numbness of the hands. So my hands get numb. They don't they sleep, it's been the same since October last year. But then I go and then I told them about this and they're like no But it is chest and then the arm then you need to go to the ambulance. I'm like no it's been like one year for months. Yeah, and nothing is being done about it. No, it's been more than a year and it's like oh, yeah, but it's I don't know what to say like your hands get numb and sleepy and your heart pain and the arm pain and then I'm like, yeah and they and then I had so much bleeding. I had to go to the hospital because I was bleeding and bleeding. Like my menstrual cycle like after the vaccine many things happened the menstrual cycle was like fucked up And then they I was like doing like a lot of bleeding and non-stop for one month almost. So I was like concerned. Then one month and then they're like well you should go home and I'm like and then what should I do is like one month Of bleeding and they're like well just wait until it stops.
R: And how did that make you feel?

IM03: Really shitty. Come on, like you're not gonna investigate like there's something going on her. Like I told you like this is an effect. I have been regular all my life 45 years and now I take this vaccine then it's this problem. You should investigate. This is like something you need to investigate. And then they told me well, it's been a problem for many women that they're having problems after the vaccine like that. Then you should say also to all the people that are taking the vaccine. Do you want to retake it or do you want to do this? Now all the data. Yeah, you should collect this data of all these people. They're like no, it just happens. It just happens and we don't know like why, like it's not important enough for them to know. So then you're bleeding so go home bleed and then when it stops and then it stops So then I came home and yeah, I stayed home and that was the first time I went to the hospital. Then the second time was about the heart thing that issue. And that was another one and then another one was an infection vaginal infection and they just said to me like there's just some regular infection, but they didn't like prescribe anything. They just said water and water. Yeah but why is this happening? Like can you investigate a little bit more? So they treat the symptoms, but they don't really seek out the causes
R: And is there anything you would like to change about your relationship with your fastlege? Would you like her to investigate your problems more?
IM03: I think so. Yeah, I could come on I mean like I am already telling you that this happened and I was a healthy person and now I am having all these things and it's something that they were obligating because you needed like this QR code to go out and in and now I'm like what is it? Can you investigate like where are the chemicals inside the vaccine and that have affected my life? I don't know. And the chemicals inside the vaccine that have affected me and many other woman can you investigate about this because if you said because they told me a lot of women are coming now with these problems and i'm like but who's gonna address that? Yeah, that's the only thing that I would try to ask like if they could at least try to make like a statistic at least to investigate the problems, what is causing your symptom. And not just act like I'll just give you things that are gonna fix you a little bit.
R: And do you believe that the medical treatment you receive here is adequate to your needs?
IM03: I Think it's okay.
R: So even though you had had some problems and you would like something's changed you still think it's it's okay for you?
IM03: yeah, I think the only thing we need to change is like the emergency thing is like There so many emergencies and they have very few doctors so then the emergency is like Takes a lot of time there. I need to stay there for a long period of time in the lab But that's the only thing I would recommend like the wait is too long. Yeah, that's more like a staffing issue
R: You think there's not enough doctors and not enough staff to deal with all the people? and that's both in the fastlege and the legevakt?
IM03: Yes. There's a lot of waiting. Yeah I think in both they need more medical personnel
R: and in your perspective, how does the health care medical services here affect your everyday life? Does it make you feel insecure? Does it make you feel?
IM03: In a way I feel comfortable it's okay I know that they're gonna take care of me and it's if something happens, but it has to be super extremely urgent and like very I don't know like very serious almost life and death then I think it will be okay. But the rest of the other things issues that happen in your health I don't feel as comfortable.
R: so you think that like it's very good if you're have something very serious but if it's not serious enough they just let it go?
IM03: Yes. Because it's not serious for them. So then but I was thinking to myself like okay, like I have this issue with the muscle and they say it about the heart and it's not an issue now But then they investigate and they say no, it's not an issue. Okay, but what is causing this pain like they don't investigate so then it's okay. So who can I go to? It would be nice to know. I can

pay I want to investigate what is going on with me? Yeah, I will pay extra but I want to investigate.
R: And you don't know how to go about that how to get a specialist or anything like that and it was never informed to you how you can do it?
Im03: I don't know.
R: And is there anything that's not medical related that prevents you from seeking health care when you're in need? You mentioned a little bit. You mentioned mentioned time that it takes too much time. And is there anything else?
IM03: Also like, you know, I don't want to do it anymore because I feel like I'm an immigrant Yeah so I shouldn't misspend the money of the people here. So I'm like, yeah, I should not go there anymore.
R: So you don't feel comfortable using even though you have to pay a like a small fee and taxes?
IM03: Yeah, but I still don't feel comfortable Yeah, I feel like they're gonna say oh this person. I don't know like in my mind I'm thinking oh this person have already been to the doctor like three four times and to the hospital two times So they're like, oh she's a sick person. Then we should not renew her visa or something like this Yeah, and I'm afraid of that. Yeah, so I'm afraid.
R: Do you believe that? Do you believe that well you just mentioned that being an immigrant has impacted the way you go about seeking medical care here, and have you ever felt? discriminated based on your immigrant background
IM03: No.
R: Is there anything else you would like to mention about your experiences and how you feel?
IM03: I think the best thing is that you don't have to spend that much money yeah, and that they take tests and then you can pay some tests Like you said, yeah, but they don't have to pay that much. Yeah, so it's not that expensive. It's not that expensive.
But the only I think how can I get more if I want to get more? Yeah, can I do that? Like I would like to know and but now I like I tell you I don't want to do anything because I'm just thinking about my visa I don't wanna to be like Like a problem.

INTERVIEW IMMIGRANT 04
R: Alright, so this is interview with immigrant number four. And just before we start, where are you from? Just so I have a...
IM04: I grew up in Seattle. In Seattle. Yeah. I lived there until I moved to Norway. Yeah.
R: And it's just a little bit about your knowledge about the healthcare here. And do you know what channels you have to go through to properly seek out medical help here?
IM04: Yeah.
R: And do you find it easy to do that?
IM04: Moderately. Yeah? Yeah.
R: What are the difficulties that you think that are there?
IM04: Getting through to the doctor on the phone. On the phone, yeah. And then waiting times. Yeah. Yeah.
R: And have you ever had any difficulties understanding how to properly use the medical services available?

IM04: When we first arrived, which was in the 80s, I had a really hard time understanding the hälsestation. Yeah. That all well child care, all access for children to the health services seemed to go through that, but they wouldn't see you if the child was ill. You could only bring your child there when they were well. We moved here with a child who had a chronic illness that was already diagnosed. And there was no mechanism for us to get in touch with the specialist service because it was like she had to be diagnosed all over again. Yeah. And things were much more, just slower and harder to navigate then. Yeah.
R: And do you know which health care systems are available and how to reach them? Yeah. Yeah. And when you first moved here, you didn't...
IM04: When I first moved here, I knew that you couldn't refer yourself to the specialist level. I knew that. I wasn't prepared for how basic general practitioners were. Yeah. And how unused to the patient having an opinion they were. Yeah. It was a bit of an adjustment. Yeah. Actually, when I got here, I got a job right away. I mean, like the first week I went to the hospital because I'm a nurse, I was a nurse then and I wondered about getting a job and they didn't have any job openings, but they needed summer fill in. People, oh, you're a nurse. You can take a shift tomorrow night. I can. I didn't have my... I don't know who this is. I don't remember. I don't know who it was. Yeah. It was... And I thought, well, all right. I'd never... I really hadn't worked in hospitals and they set me loose on a men's urology floor with absolutely no orientation. They didn't even show me how to call, how to... If somebody had a cardiac arrest, what I was supposed to do. The head nurse at the hospital was happy to help me. And I was supposed to prepare all the medications for the morning round that the day shift would do. Yeah. I had never worked in a system that didn't have a hospital pharmacy where they sent up a cart with all the... With everything already prepared. And they had unlocked drawers for each patient, which was something that appeared in Norway some years later. But that was my education. And I'm standing there, supposed to be finding things in this medicine cabinet with a whole bunch of white tablets that all looked identical. I'm supposed to put them in little steel cups. I had no idea what the medications were. And this nurse was perfectly happy to let me do that. And I came home and said to my husband, if I get seriously ill, you put me on the first plane home. Because I'm not going to this hospital. It's better now. Yeah, but both from the working side that you had and the immigrant side, there was no explanation of how anything in the healthcare worked. You were just kind of thrown... I was told where to go to get a uniform to put on so I could go to work.
R: And that was it?
IM04: That was it. And as an immigrant... And she asked me no questions. She didn't even ask me to prove that I was a nurse.
R: It's not like that anymore.
IM04: No, thankfully. Yes, but it's...
R: But we did have a case in the hospital not long ago with the orthopedist.
IM04: Yeah, with the... Yes. Well, yeah. So it's still not that great. It's still not perfect. No. Yeah. But I mean, that is a huge case because it is an aberration. But still, it's not acceptable. Yeah. Yeah.
R: But from an... But now I know... As an immigrant, like... As an immigrant. Did they teach you how to use the medical system or what are your options?
IM04: Well, your options... At that point, your options were to take it or leave it. There weren't any other options. There weren't options. There weren't. And so that was simple, you know?
R: And how did that make you feel like...
IM04: It made me feel unsafe. But I came from a system that was supposedly based on the Nordic model where we had a health insurance system where you also couldn't self-refer to specialists. And it worked really well. There weren't waiting times of months or waiting times of maybe a week. Yeah. And shorter if it was an emergency. So I was surprised that things

were so inefficient and really surprised. And given that they had way better staff ratios and they had a healthier population, it seemed really ridiculous that the services were so inefficient. Yeah. I remember thinking, what this place needs is a couple of really good lawsuits to get them to pull their socks up. It's not easy to do lawsuits in Norway as well. It's not like in the States. Although, this was even before they had the Patientska Rødhøstakling. Yeah. So it was just unheard of. People just didn't do that. It was like, why would you sue the health services? They just have your best interest at heart. So people were very trusting. They still are, mostly. And with reason. One of the things you don't have to worry about here is that somebody's going to recommend that you have some procedure without you needing it. Because they have nothing to earn from it. Yeah, because there's no monetary gain from it. There's no monetary gain to treating people unnecessarily. But sometimes, you're like, okay. Sometimes there's things that should be done that aren't done because it costs too much. And then you're in the other... The other side of the spectrum. The other extreme. Yeah. Yeah. So, yeah. But I know how to access care in the system. And I have worked in it. And I know it. And it still doesn't always make it easy. But it means that I am much more impatient about it when it doesn't work. And I'm not afraid to complain.
R: That's good. That's really good. More people should complain.
IM04: Yeah, because if you don't complain, nothing ever changes.
R: And usually, how long after you present symptoms do you seek out medical care?
IM04: It depends on what the symptom is. But, I mean, I've had a cough now for a month. But I haven't had a fever. And I'm feeling okay. So, I haven't bothered talking to my doctor about it because I know I'm not really that ill. I'm getting better now. But if I have an acute symptom, I sprained my foot. I went right away to acute care. But if it's something mild, you usually put out seeking out medical care. Yeah, I mean, I think partly because of my work, I know the difference between things that are emergencies and things that you can wait for a day or two. But to be honest, if something happens on a Friday afternoon, like, okay, I'd much rather not have to go to the acute care facility because I don't think I'll get adequate attention there. And it's going to take a long time. So, it's possible I sometimes make a decision based on how unpleasant it is to seek care. Although, if it was something important, yeah. If it was something really big. I had chest pain. And I called the acute number in the middle of the day and an ambulance came and got me. And I've never done that before. And it was actually very satisfying. I mean, they were totally professional. And when I called and just said, chest pain, where do I send the ambulance? She wanted to send a car to me right away. Right away. I don't remember if I said how old I was, but it was like she kept me on the line. She said, don't get up. So, they took it very seriously. Really seriously, yeah. And so, that's sort of my experience. If you get over the threshold for being considered acute, you get fantastic care. But if you're not there yet. But if you're not there, it's like, it doesn't matter. We'll get to you when we get to you. Yeah, or maybe it'll get better by itself. Yeah.
R: And do you find it easy to seek out medical care here? Or does the waiting times and things like that make it?
IM04: It's easy enough. It's not an obstacle. I don't have trouble communicating most of the time. But also because I have a doctor in a doctor's office that I'm happy with now. I think the staff there are really good. The clerical staff also has a lot of autonomy. And they're knowledgeable. So, they seem to know the difference between something that needs a doctor's attention and something that they can handle. I really like how that office works. My previous doctor wasn't like that.
R: Yeah. So, you changed your fast leg here.
IM04: I changed, yeah.
R: Why did you? What made you change?

IM04: It was that. It was that I realized that my communication with my doctor was just a person-to-person thing. It was so bad that it was a danger to my health. Yeah. Because she didn't take me seriously. And there was something about...
R: So, she dismissed your concerns and...
IM04: She just didn't take them in at all. And then when she did, she was supposed to refer me for something. And she left the form under some other papers on her desk. And it didn't get sent for days. And... I just said, had enough. Yeah.
R: You had no trust in her anymore.
IM04: I had no trust in my ability to communicate my needs to her in a way that she would understand. And I had been happy with her for years. But when I all of a sudden really needed a doctor who was on my wavelength, I realized that it wasn't her. And I found a new doctor who I was really, really happy with. And then she left. But the person who came after her was also fine. And I've come to appreciate the functioning of that whole practice. I just think they're really good. So, there are some who are really good and some that aren't. But I've been lucky also. My job at the hospital has meant that I have looked at a lot of medical records. So, I have a sort of impression of how doctors are. So, there were some doctors that it would never occur to me to try and get on their case logs. You already knew which doctors sort of to avoid in a way. Yeah. I had my biases anyway. And some people might be happy with them, but I knew that I wouldn't be. Yeah. So, because of my particular status, I had an easier time finding my way around it. And because of working in the system, you know what to expect and you sort of know where to push when you need to. Yeah. And you know where it's not going to help.
R: And do you trust your fast leg now? Is he a man or a woman?
IM04: He's a woman.
R: You have a woman still. And do you trust her?
IM04: Yeah. I do.
R: And do you feel comfortable sharing any type of information that can affect your health or your treatment with her?
IM04: I guess so. I mean, I don't think I've held back on anything that was a concern that I wanted to bring up with her. Yeah. But actually, it's a good question. It's possible there are things that in another setting I might have brought up. Yeah. But she's so much younger than me that I don't know if she would understand.
R: So, that's the thing that makes you maybe not share is the age difference.
IM04: Yeah. I haven't really, but to be fair to her, I haven't really tested her on that.
R: Tested her.
IM04: Yeah. And I like the response that she has had to the concerns I have raised. Yeah. I like that she is informative, that she takes me seriously. That's really important. Yeah. It is. And that she isn't bothered by me having knowledge. That also can be a very big problem. That doctors are a big resistance when...
R: So, you feel her by her?
IM04: I feel, yeah. Yeah. Which is different. She's not always there, but when she isn't there, they have junior doctors and doctors who are on rotation doing sort of preceptorships there. Yeah. And they always manage to see me in a timely way. Yeah. And the person that I see, it looks like they're very comfortable asking for help from one of the senior doctors if they need it. Yeah. And my perception of the whole practice is that it functions well. That it's okay to not know everything. They don't expect these fill-ins to just take over their job for them. They're there to learn and it seems to be a good learning place. So, there are a lot of things about that practice that I appreciate and I let them know, in fact, because I don't think it's that common.
R: No. I don't think it is either. And is there anything you'd like to change regarding your relationship with your fastlege?
IM04: At this point, no.

R: No. You're very satisfied with her?
IM04: I'm satisfied, yeah.
R: And do you feel that the medical personnel here and your fastlege in other places that you've been to is forthcoming and provides you with enough information to make informed decisions?
IM04: I feel like my doctor is. Yeah. Yeah.
R: But in other places?
IM04: I've met doctors that I felt like just didn't really care or didn't listen or were irritated by being asked questions and I just don't go back. Yeah. Unless I absolutely have to and I have never chosen a doctor like that. Yeah. I've just thought, okay, I'm out of here.
R: And do you think you receive enough feedback about your health?
IM04: From my doctor?
R: Yeah.
IM04: I don't think I need a lot. Yeah. But also because I'm above average well-informed about my health. Yeah. I'm not really dependent on my doctor to tell me everything, but I appreciate that I get my test results. If I do any kinds of blood tests, I get the results automatically. I don't have to beg for them. Yeah.
R: Your doctor provides it for you.
IM04: Yeah.
R: Did you request that at some point?
IM04: I think probably, but I don't remember. But it's just a non-issue. Yeah.
R: So you feel like there's a good transparency with your medical history from... Yeah. You don't have an issue with that?
IM04: Not with... no. No. But it's really different here. Like when you sign up with a practice, they don't really... They're not interested in knowing anything about your history when you show up. No. They don't know anything about your family history. They don't know anything about any risk factors you might have for anything. It's just, hi, you're my patient. Okay. Let's just start from scratch. Let's start from scratch, which seems weird to me, but I went through a history-taking form in another context that, through my work, we were translating it to use here. And I thought, do we really need to ask people all this stuff? Because there was a lot of stuff that is common to ask in the U.S. Yeah. Where I'm trained that is just completely irrelevant, and it's a waste of time. Yeah. And then there's all this basic stuff in the middle that I think they should be more aware of getting here.
R: Yeah, so there's not a lot of history-taking here in the medical sense.
IM04: No.
R: Is there anything non-medical related that prevents you from seeking health care when you're in need?
IM04: Non-medical? No. Yeah.
R: You mentioned that if you're sick on a Friday afternoon...
IM04: Yeah, yeah.
R: Why wouldn't you seek medical care then?
IM04: Because the leg of ox is just such a drag. You just think that it's a bigger hassle than it's worth. Yeah. If it's something that I can take some Paracet and see if it goes away, I'll do that instead.
R: So it's more regarding the amount of time that it takes to...
IM04: Time and the possible benefit, because you don't know who you'll run into there either. So the cost-benefit doesn't... And especially now in the pandemic, I'm going to sit there in the waiting room, and who knows what I'm going to get exposed to. So, yeah, it's just sort of... Should I, should I not? But I'm not the kind of person who enjoys sitting in waiting rooms. Yeah. Especially for hours and hours. When you don't know who you're going to see, odds are it's not somebody who's as good as your regular doctor.

R: And do you believe that the medical treatment you receive here is adequate to your needs?
IM04: Yeah. Yeah.
R: You don't have any reservations about it or anything?
IM04: Yes and no. I think on a daily basis, it's adequate. But I had an injury to my hand, and... I had a small operation on my thumb joint, and when I got the cast off... The orthopedist at the hospital, he just took off the cast, and he said, well, you know, we're done here. And I said, I'd like a referral for physical therapy. Because I've had my hand immobilized for six weeks. It loses the... Oh, yeah, yeah, of course, yeah. And he filled it out. But I had to bring it up, and I thought... So this is weird. I already had an appointment. I had made an appointment when I got the cast on. And this could also be because you're more informed about your health. So someone else wouldn't know to ask. And then when they finally realize that things aren't okay, then they have to make an appointment with their doctor. And then they have to try and find a physical therapist. And months have passed by then, and every day matters. So I had an appointment for the next day with a physical therapist. I knew I had made the appointment, and I thought, I'll have the referral in my hand when I get there. But I wouldn't have had it if I hadn't requested it myself. So there's not a lot of proactiveness in things that are not life-threatening. Yeah, and really odd, because it's just blatantly obvious that physical therapy is necessary when you get a cast off.
R: Do you feel like there's a good amount of preventive medicine here in Norway?
IM04: It's there, but it's not always used. And they have these ideas about how it should be provided, like urban planning is part of it, to plan living spaces that encourage people to use their feet to get places instead of driving, and making spaces that are inviting to spend time outside in, and things like that. But it's under-communicated. So communication is a big issue. Yeah, and how they package that message and how they get it out to people, it's sort of coming, but I don't know. When you think about commercial enterprises, how they advertise things and how effective they are getting their message across, and then how the public health messaging is, it's probably the same everywhere. Public health messaging is kind of... It's not as snappy and not as flashy and not as effective.
R: No, it's not as effective. And in your perspective, how does the health care services here affect your everyday life?
IM04: Everyday life? Yeah. Well, I take two medications that I get on the blood receptor, for blood pressure and cholesterol. And it costs me about two kroner per day for the whole... That's what I pay for life-saving medication. So how that affects my daily life is that I know I can afford the medication I need.
R: You have no fear of going bankrupt over your medical needs?
IM04: No.
R: It makes you feel more safe?
IM04: Much more safe than I would be in the US, for example, where the safety net is... It's not there. I can't call it that. It's a hallucination or something. It just doesn't exist. And every time I go and get my prescriptions... Every time I go and collect my prescriptions, I say something at the pharmacy. I say, this is a fantastic arrangement. I show up here. I show my ID card. I get these medications. I pay a joke for it. I didn't even notice how much it costs. I know now because I paid 140 kroner recently for three months' supply. Yeah. It makes you feel safe knowing that, in a way, the health care system is there. Yeah. Yeah. And that if something catastrophic happens to me, it's there. Yeah. It's sort of... But it's those day-to-day things. If you have chronic pain, it takes a long time to get heard. Yeah. And maybe more so as a woman. You have sort of diffuse things. And I have relatives who have chronic illness that it's not dealt with well anywhere, and especially not in women. And they're not in danger of losing their homes, but getting taken seriously is really hard. Yeah. Yeah. And if it's a condition that isn't officially recognized and well enough established that care for it is in the system, it's

expensive. Yeah. Yeah. So unless you fit in the box of what they expect. Yeah. But even when you don't, I always have to mentally compare it to what I would pay in the U.S. where the same medications that we still have to pay out-of-pocket for here, paying out-of-pocket for the R.O.B. Are still much cheaper. I mean, ten times as much. I'm not exaggerating. Yeah.
R: So by comparison, it's still better.
IM04: By comparison, it's still better. Yeah. Yeah.
R: Do you believe that being an immigrant has impacted your medical treatment in any way?
IM04: Possibly. I think being a woman has impacted it more.
R: More?
IM04: Yeah.
R: How so?
IM04: Because I was fluent in Norwegian when we got here and I already had a nursing degree. Yeah. So speaking the language helped. It really helps to speak the language and to speak the medical language. And I was used to advocating for myself from my background in the U.S. So for me specifically, I think being an immigrant has had less impact. But I've certainly seen it in my work that women who don't speak Norwegian and especially non-European immigrants get blown off. And if you come from Latin America or Asia, not so much Asia but Africa or the Middle East, and you're a woman and you come in for care, like in labor, if you're in pain, it's, oh, well, it's our culture to scream and yell. And she's like, well, she's in pain. She's in labor. Our culture is to give pain relief. And we don't care what culture she comes from. If she's in pain, she's in our culture. We should relieve her pain. And there's sort of a laxness about providing information about even basic things because, oh, in their culture, they don't believe that colostrum is enough in the first week of life. So there's no point in explaining to this woman how giving bottles of formula is going to negatively impact her breastfeeding because there's no point in saying it. So there's a big stereotyping. There's a lot of stereotyping, a lot of laziness. And I know that they don't use interpreters enough because it's inconvenient, it's hard. It's usually over the phone. It's not always adequate. And I've seen a lot of instances where when they use interpreters, the perception of the health professional is the interpreter is going to, I'm going to tell this woman everything she needs to know through the interpreter. And the idea that they could also use the interpreter to let the woman ask them things or confirm that she has understood what she said to them is just not on their radar. So it's much more of a top-bottom relationship. And the interpreter is a help for me to tell you what I think you should know. They don't see it as a... And it's not a way for me to make sure that I have gotten all the information I need from you to give you safe care. So, yeah, that's a whole nother... A whole nother problem right there.
R: And have you ever felt discriminated based on your immigrant background by your fastlege or anywhere else in the health care system?
IM04: We had an episode when we first got here with our daughter. Because she had this chronic illness and I was trying to access care for her on a weekend. And I had a real concern. And when we called the Legevakt and I said something about we were from the United States and they would have... And I was told that if this complication arose that I had to seek care immediately, well, maybe you should just go back there then if you don't like how we are. And I thought... I hung up. And the doctor called back. I think he got scared. But it was way out of line. But I don't... I don't think I felt that. I maybe felt in a work context I've been looked at oddly because I'm a foreigner.
R: Yeah, but not as a patient.
IM04: Not as a patient. Don't think so.
R: Is there anything else you want to talk about? Like mention or something? About how you feel about the medical care here or...

IM04: It's just... I remember when we got here I felt like they were really chauvinistic. When I was getting my nursing degree, registered here, and I know that my nursing training was way ahead of what current nursing training was in Norway because there were two master's students at my nursing school. There were these two master's students from Norway who were in nursing, who were doing their master's on nursing education, and they both went back to work in the health administration at the national level implementing changes to nursing education based on the curriculum at my school. But when I came here I was like, oh, well, I'll take your degree. It's good enough. Even though it was a university degree, it took me more than four years to complete it because that's how long it took. And here nursing was a two-year thing that was basically an apprenticeship with no theory. But they didn't think that I would be safe to practice here.
R: Norway thinks.
IM04: Yeah. And I had to apply. There's this course that you have to take, a three-week course for foreign-trained nurses. They didn't even tell me about that course because they figured I would need a couple of years to learn the language, even though I had sent my application in Norwegian. Oh, we just assumed your husband had written it. And I said, did you see I have a degree in Norwegian, a four-year degree in Norwegian language? But I hear from talking to you that you're fine to come to this course. So I got to go to the course the first, just a few months after we got here. But it was only because I was able to call up and tell them what I thought. And they caved right away. So that was the other thing. I found that the bureaucracy seemed very monolithic. But if you just didn't take no for an answer, there was no resistance. Yeah. It was like they relied on you just... They relied on your complacency. Yeah, and just going away. Oh, they said no, okay. And if you said, wait just a minute, then they had no plan B, which was great because I got my license pretty quickly. And I deserved to. But then it turned out, and I didn't know this, it turned out that one of the professors at my college, she was the author of the basic nursing text that was used all through Norway, although it wasn't the latest edition because that hadn't been translated yet. But they still were so skeptical to the idea that somebody trained in the US could... Could practice here. Could be competent to practice nursing in Norway. I haven't tried to get licensed anywhere else. Now there's reciprocity. Yeah, between the countries. Not between the US and Norway yet, and it's still an immense barrier to getting licensed. But they didn't even tell us that we had the option of appealing if they rejected our application. And that I learned at this three-week course that I managed to weasel my way into. So I had been told that no, I couldn't get my license without doing a whole bunch of clinical practice. They wanted me to work for like three weeks full-time in geriatrics, like in a nursing home. And because they couldn't see that I had had enough geriatrics in my training, I had had enough geriatrics in my training. But part of the course was learning about... Your rights. ...forvaltningsloven. Yeah. So at the next break, I was on the streetcar down to the bureaucracy, and I found the person who had signed my letter saying, no, no, you can't be licensed. And it all sorted itself out. But it was... I mean, it's ridiculous that you have to have that level of knowledge. And after that, they started putting appeals form in when they sent the rejection. But they were just sort of... they were so amateurish that it was... Yeah, it was just very... It was almost amusing if it hadn't been such a pain. It was like, how can this be? This country that has great statistics, even then, they... Norway scored really high on health indicators. Yeah. But... Statistics don't always tell the whole story. No. No, and the outcomes they look at, you know, death rates by age, it's a fairly coarse criterion. It's very... yeah.
R: Yeah. Yeah, but that's about it, I guess. Yeah. Thank you very much.

INTERVIEW IMMIGRANT 05

R: Okay, this is interview with immigrant 5. So just to start, where are you from?
IM05: I'm from Italy.
R: Alright, so we're just going to start a little bit about what do you know about the healthcare system here in Norway? Like do you know how to properly seek out medical care here?
IM05: I do, to some extent.
R: What is your, have you ever had difficulties understanding how to use these medical services?
IM05: No because I date a Norwegian, so he helps me and of course he knows the right way to go about it, but I don't, if I were alone coming to the country, then I don't think I would know straight away. I would probably know my doctor and then rely on my primary doctor to get me through the system and tell me where to go.
R: So when you first got here, there was no explanation or information like where do you go to look for it so that you can learn how to navigate the system?
IM05: No I just got, I don't remember, I think I just got the ID number and then I got a letter saying what doctor, I was assigned to a doctor and that was it. And there's no contact detail, and yeah, just that, no other information.
R: And do you know like which healthcare systems are available and how to reach them? Do you know the different ones and how to use all of them?
IM05: I know the VAC, like a VAC, and I know my doctor, that's it. I don't even know like, I think, yeah, like a VAC would be the emergency and also consultation, yeah, that's all I know.
R: Do you know that for instance you're entitled to have a translator with you whenever you seek out medical help? You don't know?
IM05: No!
R: That was never explained to you?
IM05: No, never.
R: That was not a type of information that was ever made available to you?
IM05: No, I don't know my rights.
R: Yeah, even by your doctor, he never mentioned that to you or anything like that?
IM05: No.
R: And what do you think about that, this lack of?
IM05: Yeah, like I think that in the region, way of doing things is a little bit jumbled, I feel, so I don't think that you have access, it's like there's no easy avenue, it's an open avenue to information, you sort of stumble across on things, upon things, so I think that that hurts the user, and I think that relying only on your doctor for everything, including referrals, is a little bit limiting, especially because you don't get an appointment that easily, and then you have to sit and wait for the appointment for you to get the referral and be sent somewhere else, trusting that your doctor is actually sending you somewhere, so I feel like it's a very controlled system that do not inform much and do not give you the choice of seeking anything on your own.
R: So you feel like there's not a lot of autonomy for yourself to decide about your medical
IM05: No, you have, yeah, you're locked in place, because the system is so tight and almost scared, like you can't really move within it, no flexibility, I feel like, yeah.
R: Yeah, and do you trust your fastlege?
IM05: No.
R: You don't trust him. Is it a he or is it a she?
IM05: It's a he. I don't trust him, no.
R: Why would you, why do you feel that way?
IM05: Because I think the consultation is too fast, and I'm barely examined, and there's a lot of waiting and a lot of hesitation around prescription, around referrals, I think it's almost like you have to physically fight them to get what you want.
R: So you don't feel heard by him?

IM05: I don't feel heard, or I don't feel that there is a true worry when you bring a problem forward, I don't think that they'll get the attention that it deserves in your opinion.
R: So do you feel like medical personnel here is forthcoming and provides you enough information to make good decisions about your health?
IM05: No, because it's too fast. It's impossible in an appointment of 10 minutes, 15 minutes tops, that you're going to get the information you want. You barely can explain what your problem is. So you just feel like it's too rushed and there's no... No, it's go, go, go, next, next, next.
R: And do you think you receive enough feedback about your health?
IM05: What is that? No. No. Not at all. Not at all. Feedback? Like, no. Nothing. Nothing.
R: And what do you think about that?
IM05: Yeah, there's like no even, there isn't even a follow-up. Like, they don't even remember when you were there last. Like, it's very personal.
R: And what do you feel about that?
IM05: I feel that it's unsafe. Unsafe. I, for example, I know for a fact that if I get sick here, I will get very sick. If I develop cancer, if I develop like something first, it won't be found out until it's too late. So I'm always unsafe. Like, do I, I'm 42, so I'm always thinking, do I really want to age in this country? Like, if I go back home, I know for a fact that I would have access to more diagnosis, more exams, and I would be able to find things.
R: So you feel like there's no proactiveness, there's no preventive medicine.
IM05: No. Not at all. Not at all. And it's unsafe.
R: Yeah, and do you think that, what about like transparency regarding your medical information? Do you feel you have access?
IM05: Oh, no. That is, no. No. No. One thing that bothers me the most is not being, having to request to see the results of my lab tests and everything else. Like, and then what I get is not even the result per se. I get a typed letter from the doctor with the results, and there isn't even enough information for me to Google. The numbers, like the reference numbers are not clear. So I'm like, I get this unofficial document, in a sense. So that is withholding information for myself. And I have to actually request and chase to get it. It should come, like there should be a login that I have access to my results. They're mine.
R: So definitely. And this lack of transparency is something that bothers you the most.
IM05: Yeah, because it's just, it's a reflection of this very controlled system in which we have no say. We are like, I think we're like hostages of this very shady, locked in place system. Don't you think? It's like, you can't, so that feels, again, unsafe, because I am a person who likes control. I want to know what the hell is happening, and then I have to like struggle and sort of like chase people to know. So you have to be, you have to bother the doctor a lot in order to get anything. And you're met with a little bit of resistance, a little bit like, there's an air of like, why? Like, are you bringing this up? I got your results. Like, well, but I know I'm not blind, deaf. I want to see, I want to know, I want to keep a record. If I move tomorrow, I want to take it with me. Like, you know, there is more than this for walls.
R: Do you feel comfortable sharing any type of information that could affect your health and treatment with your fastlege?
IM05: I, this is a hard one. Well, if I must.
R: Because you mentioned you don't have a relationship of trust with him.
IM05: No, I don't, because it's not even a relationship, is it? Yeah. Yeah, so I will share. No, I feel okay. I share what I have to share.
R: Yeah, share what you have to share. And have you ever changed your first leg here?
IM05: I did. I never went to the first one they assigned. I got the one that my friends had. Yeah. So yeah, so everybody, all the fellow people, the group of people go to the same one. So I managed to change.

R: And is there anything you would like to change regarding your relationship with your first leg?
IM05: No, I've heard that he's actually very accessible. And booking an apartment with him is better if you compare to other first leg. So I don't think that I would like to, I don't think that he is necessarily the problem.
R: Yeah, you think it's more the system.
IM05: I think it's the system.
R: That creates an environment in which he himself cannot even perform his job as well.
IM05: Exactly. I don't think that there is any space for change.
R: Yeah, you think it's too stuck in its ways. Yeah. And how long after presenting symptoms do you usually seek out medical care?
IM05: I am actually very fast because I don't sit with discomfort. Yeah. So it is straight away, pretty much.
R: Do you think you can get answers in a timely manner here? You can get an appointment in a timely manner?
IM05: First leg, normally, if you call them, like, something I usually had was urinary infection. That one, you would get an appointment straight away. Not necessarily with your doctor. Yeah. Yeah. Or you go to the first leg. So I've been, that I haven't had a problem. Like, these first infections that they know need attention straight away, I've never had a problem.
R: Yeah. And do you find it easy to seek out medical care here?
IM05: Yeah. Yeah, it's okay. It's okay. Yeah.
R: And do you believe that the medical treatment you receive is adequate to your needs?
IM05: Because I haven't had a lot of needs, like, serious. I think it was okay. Yeah, I had one episode recently that I was ursic. And I think that I should have had a small procedure, a small surgery. But then, of course, they sent me back home and I was bleeding a lot. And it was like, they made me sort of work with it a few days. And if it didn't stop bleeding, then they wouldn't make a procedure. So, and there was not even my doctor that saw me that day, because it was an emergency. So, yeah, I don't think that, I'm just waiting for that to happen again and then I have a problem again. So, I feel that I got to see a person, but then the system locks you. It's again, the system, he called someone, he wanted me to have the surgery, the procedure, and they sort of said no. Yeah. Send her back, do this, do that. There's too many barriers to getting anything done. Yeah, you're only going to get proper medical care, like, really long-lasting. Yeah. If it's something, like, it's in the last of the last of the last resource. So, you feel like, unless it's something very serious, they just kind of push it backward. Yeah, even if it's serious, they will wait until... Until they have no other option but to do something. And that for me is not good.
R: Yeah. And how do you think the healthcare systems affect your everyday life? How does it make you feel knowing the healthcare system?
IM05: It makes me think that I should not live here a long time, that I should not age here. Yeah. Honestly.
R: You're afraid of aging here.
IM05: I am afraid of aging here. Because, like, for example, you cannot get a checkup, a cancer scan, for example. Like, in other countries, you can go and you can get, like, a top-to-bottom image test or whatever to just check. Even if you want to pay for it here, you're still not able, yeah. You can't. You can't do anything, like, nothing. You just have to wait until you have a very strong pain. And then imagine, if you have a strong pain and you think it might be cancer, still it's going to take you a long while of pain to get checked, properly checked, for the most serious stuff. And then it might be too late. So, like, this is something I, so, yeah, it affects my choices pretty much for the future.
R: So it makes you think that you're not going to stay here.

IM05: I don't think I will age here, maybe. I will probably get the pension and go. Work until you're entitled to the pension and then move somewhere with better medical care.
R: Yeah. So that's a big factor in deciding your future.
IM05: Huge, huge factor.
R: The fact that you don't trust the medical system here.
IM05: Yeah, and even if I were reproductive age, which, by the way, I'm not, I would maybe not have my kid here. So, yeah, it is a huge decisive factor.
R: And is there anything that's not medical related that prevents you from seeking medical treatment when you're in need of it?
IM05: No, because, again, I date someone from the region, but if I didn't date someone from the region, then it would be the language. It would be the language. I feel that, for example, my gynecologist has a very broken English, so I need to sort of bring my boyfriend in most of the consultation to help her out with translation.
R: And how does that make you feel, that you have to have, like...
IM05: Yeah, it's terrible, because then, again, it's already a very limited consultation. It lasts very short. The person, the doctor's not that into conversation, and then there's a language limiting the doctor to actually give me information. And if she's speaking in the region about me, I feel that I lose control. And I have to rely on a translation, so it's horrible. So, once again, it comes about the fact that there's no autonomy for you, and there's not enough information about your own medical history. Yeah, and I didn't know that I could have a translator there, so... Yeah. That would be an impartial person, so...
R: And do you believe that being an immigrant has impacted your treatment in any way here? You mentioned the language barrier. Yeah. And anything else there?
IM05: No, I don't... No, that, no. I don't think so.
R: And have you ever felt discriminated based on your immigrant background by your fast-legging or any other medical personnel?
IM05: No.
R: So you don't think any of those things have been a problem? And what is your perception in general about the medical care here that you receive compared to your home country?
IM05: Yeah, I think that the best... The word that best defines it is impersonal, uninterested. Uninterested. And even like... Not impersonal, how can I say? Like... Yeah, there's like a distance.
R: You don't feel like they treat you as a person?
IM05: Yeah, it's like, okay, tell me, or... Oh, another thing that I hear a lot is, about the immigration thing, is, here's how we do it. Because when you question them, like, okay, but can I see someone? Like, can I go? I want to see a gynecologist. For me, to get a gynecologist took me forever. I want to see a gynecologist. Oh, but it's not how we do it here. That I hear a lot, and it bothers me, because you see, like, it's, again, based on a very locked system, being like a tractor imposing itself on people, instead of like listening to what I want and need. What do you need right now? I'll give it to you, right? Yeah. And it's for free. So that pisses me off, because Norwegians tend to believe it's for free for some reason. It's not for free. You pay 2,000 a year, which is... Yeah, you pay your egenandel, and you pay taxes as well, so... But again, like, in England, I've lived in England, and England is, you can say it's free. Like, there's no money coming out of my account, but here, I'm paying. I'm paying for everything. So I would expect a little bit better.
R: And is there anything that you think could be improved in the medical care here that you receive as a woman?
IM05: I think that we should have re-granted access to specialists. Like, you know, like, of course, I don't have to see a urologist, or, you know, but, like, women should have their fast ligand, and then they should have a gynecologist, for example. That is their go-to person.

Because female health is very specific. So it's a waste of my time if I have to go to my, like, my, how do you say? Fast ligand. Fast ligand, and then explain to him what I have, and then he doesn't know how to help me, and then I'm going to refer you, and then he refers me in two weeks, you know? Why? I'm a woman. Of course I'm going to have to go to a gynecologist. And also, like, the smear test, they do it every five years. That is insane. The rest of the world, the protocol is a year. In England, a year. Every year, at my age, I have to get a smear test. Five fucking years? I'm sorry. Are you, like, no. Oh, and another thing, can I, can I, oh my god. Yeah, yeah, go. Another thing, I am doing, she wants me to start doing hormonal treatment, right? And then she told me that that hormone treatment might, like, increase tremendously the chance of cancer. And I'm like, okay, so fine, but then what happens, like, breast cancer, I'm like, okay, so what happens then with exams? So I have to do the exam every year for a breast? Oh no. We don't do anything like that. They don't do mammography. In a person that is doing a treatment that possibly will give her cancer. So these things I don't understand. Like, I would like to understand where they're saving money. Makes no sense. So these things, I think, they should, is it like palliative care, I think? Yeah, palliative, like. They should invest in that. Yeah, so it's a very, we'll fix a problem and it's very big, but if it's not big, we'll just, wait until it becomes big. Yeah, for some reason, which I don't understand because that is more expensive, I would say. And you're actually killing people.
R: Preventive medicine is the cheapest form of medicine.
IM05: Yeah, actually.
R: Yeah. Is there anything else you want to talk about? Oh, yeah. The medical care here, or how do you feel about your experiences with the medical system here?
IM05: Yeah, no, I think this is it. I don't see the point of having a family doctor that does not relate to you on a personal level. I feel he's just like, almost like a secretary to the specialists. So you go there, he does absolutely nothing. He just sends you to someone else. That's at least what happened to me every time. Yeah. And the other times when I know it's like just a sore throat, COVID, anything that I need, then I normally just exchange messages with him and he prescribes the stuff. So every time I go there, it's because I need a referral. So what is the purpose of it?
R: You don't feel like there's a...
IM05: I don't see the purpose. I think that he's...
R: Do you feel like he's a waste of time?
IM05: It is. Oh, yeah. And it creates more... More steps, more... Yeah. Yeah. How do you say, hoops to fall, to jump? Yeah, hoops to jump, true. Yeah. Yeah. I think that they need to revise that a little bit. I think there are... As I said, there are specialists that are obviously needed. And men, especially at an age, should have a urologist. Women should always, since young age, have access to their gynecologist, have a personal relationship with them. She's going to start my hormone thing. And then she says that I'm going to go back to be seen by my... Normal doctor. I can't say this. Yeah. And I'm like, how? I'm going to lose access to her.
R: And how do you feel about that?
IM05: I feel like I'm safe. I don't know. It's revolting. It's an uncertainty that you... It's surreal. To me, it's surreal. Because she wants me to do... I'm not going to do, by the way. I'm not following. I'm following the... For each to have an idea. I'm following the... I'm following the... I'm following the... I'm following the... I'm following the... I'm following the... I'm following the... I'm following the protocol of my home country. And my doctor. My gynecologist in my home country. Because I don't believe that she can take care of me. If she's going to make me inject stuff and not... Not follow up. Not see me anymore. After five years. So, I'm not happy.
R: So you're not happy with the whole system here at all?
IM05: No. No.
R: That was it. Thank you very much.

INTERVIEW IMMIGRANT 06

R: This is interview with immigrant 6. So first of all, where are you from?
IM06: I'm French.
R: We're just going to talk a little bit about your knowledge of the healthcare system here in Norway. Okay. And do you know how to properly seek out medical help?
IM06: I think so.
R: You think so?
IM06: I think so.
R: Why are you not sure?
IM06: Because I have not encountered very extensive medical problems. So far it's been quite straightforward. I'm not sure I would know what to do with a sudden, very specific disease, but I'd probably just go to my fastlege. Yeah, fastlege and just ask from there how to proceed.
R: And have you ever had any difficulties understanding how to properly use the medical systems that are available for you here?
IM06: I think it's been all right, but I've had a little guidance. I've had help from my local support. My family is Norwegian.
R: Your family is Norwegian?
IM06: Well, my husband's family is Norwegian. My boyfriend's family is Norwegian. So I can get help with them.
R: But have you ever had a formal, official guidance from the government?
IM06: No. When I got here, I had a little help because I came here as a student. So the university did it all for me. They gave me the Norwegian number procedure for me. So I received, without asking for it, but great, I received the Norwegian number. And then I was notified that I had a fastlege. So that was great. And I could just Google his name and find his address.
R: But other than being notified that you had a fastlege, there wasn't any information about anything else, where to go for things?
IM06: No, not whatsoever. Nothing.
R: And what do you think about that? The fact that they just tell you have a fastlege and that's it?
IM06: I think for an immigrant, not knowing Norwegian, that can be quite challenging. I think it would have been nice with some guidance. In my case, I come from France, where things would have been the same. So I wasn't surprised. I wasn't really shocked not to get guidance on the subject.
R: So it was kind of expected already?
IM06: It was expected. It didn't appall me, because I expected this.
R: And do you think that it's a good way to go about healthcare?

IM06: No, I don’t, but also, I don’t know what it’s possible to change, so you just kind of get used to it.
R: And do you know which healthcare systems are available and how to reach them here?
IM06: I know some.
R: Can you elaborate a little?
Im06: I know some for sure. I don't know if I know much, but I know some. I know what happens when you get pregnant. That I found out. Fastlege and hospital. I know about Legevakta, which I don't think is great.
R: Why don't you think Legevakta is great?
IM06: Well, the one time I really needed it, I couldn't find the number on Google. I just typed Legevakta Kristiansand, and it just didn't come. And I ended up at Kristiasand, the main hospital line. And when I came to Legevakta, they said you need to call first. And I said, well, really? I tried. I tried and said, well, it's easy. Same number. It's been for 10 years. I haven't lived here 10 years. I don't know. But I thought that was surprisingly difficult information to seek out. It should be much easier to get to Legevakta, because when you need it, you're very much in need. You're not into Googling anything. You just want it to be straightforward. And actually having to call first, I understand. I understand it's practical for them. But when it sucks really, really badly, you just want to go. You don't want to have to go through that barrier of having to call. That's not a barrier that I enjoyed when it happened. But I did get help. So that was all right. In the end, they didn't refuse me because I didn't call, but they complained a little. They complained a little about my lack of planning. that I hadn't planned ahead.
R: That you hadn't planned to be in a situation where you needed emergency help?
IM06: Yeah, I thought that was a bit rough.
R: Definitely. And how did that made you feel?
IM06: Just a little weirded out. Like, it’s an emergency, nobody plans for them. So it’s just a bit frustrating to have them complain that you didn’t plan for it.
R: And a little bit about how you go about seeking healthcare here. How long after you present symptoms do you usually seek medical help?
Im06: Hmm. I'd say two weeks. I'm very slow. I'm sort of hoping it gets better.
R: Yeah. Have you always been like that? Has it changed since you've come to Norway?
IM06: No. In France, the system is very easy. Whenever something happens, there are so many hospitals, so many places to get help. It's all free. Absolutely free. So there I'm quicker. In France, I'm quicker to get help because there is a doctor right around the corner. And yes, there are availabilities. There are always availabilities because there are so many doctors. So I'm quicker. But here, when I see that I need help, it takes at least two weeks. If it's for me, it takes at least two weeks. For my child, it's different.
R: Because you think it takes too long?
IM06: It takes too long. I know that every time I've tried to get an appointment with my doctor, sometimes it's like three weeks wait. In three weeks, I'm okay. Probably. So it's like, do I even bother? Or maybe in three weeks, it's not my doctor I need, it's a hospital. That is definitely way too long. So it's discouraging. Basically, to seek help, which is dumb because sometimes bigger problems could be avoided if you had seeked help earlier. So that I would say was definitely my main critic to the Norwegian system.
R: So you don't think there is a proactiveness and a preventive medicine here?
IM06: I think there is a wonderful effort of preventing medicine on the psychological part. Like psychological help, there is a lot of prevention for this. But actual medicine, not so much.
R: And do you find it easy to seek out medical care here? You mentioned a little bit about the time that it takes.

IM06: Yeah, it takes some time. Not any worse than in France. It is just to reach the office of a doctor. I find extremely long, the process in between. I've been waiting for two years for a surgery, which I still haven't had.
R: Two years is a very long time. How does that make you feel? That time that you were waiting for surgery, have they given you an explanation?
IM06: No, really. They've given me an explanation. I can tell you what the problem is.
R: You don't have to do that if you don't want.
IM06: It's no big deal. I'm deaf on one side. It's a problem I got in pregnancy. I lost half of my hearing in pregnancy. I very much need surgery to repair it, because I cannot hear. Now you talk to me, that's fine, because we're in a room alone. If there is any noise around, I get really shut out. Especially since I'm French, there is a barrier to the English. I've been waiting for that surgery. As I understand, I am not a priority, because I have one functioning ear. Anyone with two ears that aren't functioning properly gets priority over me. I cannot get... How do you call that? A machine to... The hearing aid. I can't get any hearing aid, because I've opted for surgery. I am navigating life without hearing much. Not knowing how long it will take to get the surgery. That's not great. Mostly, it gives anxiety. At night, I don't know if I'll hear my children if they need me. That is something I'd really love for them to help me with, but not coming. That really sucks. It takes so long. I had a feedback a few months ago. They said, we really can't help you in Kristiansand. It's going to take too long. Do you mind travelling to Frederikstad? Or to Oslo, to get the surgery. If it can be quicker, I can do that. It's been six months, and I'm still waiting for Frederikstad or Oslo. No one wants to operate on me. That's definitely way too long. I've had some bad ones. Three weeks, and it's done. You're set for surgery. It's never this long of a waiting time. Especially without knowing anything. I had to call a few times to hear if I was still on the waiting list. Have you forgotten about me? Am I still considered for surgery? Yes, you're on the waiting list. Anything I can do? No. Wait. It's been a while. That's not your best.
R:That's really awful. Do you feel they should be more forthcoming with information?
IM06: Definitely, especially because the not knowing what's happening can cause a lot of stress and anxiety. My problem is not super serious, but what about those that are? I can't imagine.
R: Me neither. Now, little bit about your fastlege. If you're okay with sharing, is your fastlege a man or a woman?
IM06: It's a man.
R: Do you trust him?
IM06: Yes, very much. He's a very nice guy.
R: You never had any issues with him? Do you feel like he hears you?
IM06: He's actually very... I'm not sure about how good he is as a doctor. Actually, because I haven't needed him so much as a doctor properly. It's always been more specific. So he sent me over to other doctors. But he's the best listener. He's wonderful. It takes time to really listen. I'm actually very thankful for him. But now he's moved to another part of town. Way off. But I still go to him because he actually cares. That's what I'm mostly looking for.
R: Do you feel comfortable sharing any type of information that can affect your health and treatment with him?
IM06: Yes, absolutely.
R: You never had any issues with that?
IM06: No.
R: Is there anything you would like to change regarding your relationship with him?
IM06: No, really. Not really.
R: Do you feel that the medical personnel here is forthcoming and provides you enough information about your medical situations?
IM06: Yes, I'd say so. It depends on who. I've been less impressed with the hearing situation. The doctor, which I thought was a bit cold. I had to fish out information. But other than that,

everything around pregnancy was absolutely amazing. People were so concerned. My fastlege is great as well. So it really depends on the person I'm talking to. But mostly I'm happy.
R: Do you think you receive enough feedback about your health? Enough feedback?
IM06: They don't seek me out. I do have to ask if I'm okay. I went to my doctor a few weeks ago because I felt I was having burnout symptoms. I was really stressed and I was wondering if physiologically that could affect me. I did have to ask, can you check? Take a blood sample or something. Check that I am in health.
R: You had to be a little more proactive.
IM06: I had to be a bit proactive there. He was listening very much to what was going on. He was very helpful there. But I really needed a doctor to say: we'll check everything. Tension, everything. I had to ask, can you check that I'm okay? You just had to put your foot down a little bit. So it wasn't too proactive there. But I made up for it.
R: Do you feel that you have good enough access to your own information? Like your medical history. Is there a transparency regarding your data and what is happening with your health?
IM06: Honestly, I'm not sure. I know that I have a journal.
R: Have you ever looked at it? Do you know where to look for it?
IM06: I've looked at it once. I'm not sure if I looked for me or for my kids. But I looked at it because I wanted to register as a donor. But I didn't find extensive information for sure. And there is absolutely no background from France. But I can't really blame them for that. It's probably on me to send information forward.
R: But they never requested any history or anything like that from you?
IM06: No, they didn't ask for it. Absolutely not. So it's a little bit more on you to provide the information and things like that. If I want to make my file complete, I have to fill it up myself. Which is a bit strange. But there was information. I can't remember what.
R: But you had access to it. So you feel that there is a good level of transparency regarding your information?
IM06: I had access to it. So that was all right.
R: Do you think that the medical treatment you receive here is adequate to your needs?
IM06: I'd say so. Besides that one, that I'm really very much waiting on.
R: So it's a bit case by case?
IM06: It's very case by case. I at least feel like my children are getting absolutely everything they need. Which is really what I'm most anxious about.
R: Overall, you think it's very good? There's just one particular case in your situation?
IM06: In my situation, one case isn't optimal. But I don't have anything to complain about regarding the rest. Just too bad with the waiting time. Because there are medical issues that have come. Which I really would have liked a little sooner help with. But I'm happy with the way my medical issues are taken seriously. By the medical system, at least. If I come in with a really bad back or bad knees or something. And I used to do some physical work. And how is it with work? Do you need rest? I feel like they were responding. They took into account your whole situation. They're not thinking I'm whining. They're actually responding and taking it seriously. So I find this quite reassuring.
R: That's really good. In your perspective, how does the availability of healthcare services here affect your everyday life?
IM06: I'm sorry, what did you say?
R: How does the availability of healthcare services here affect your everyday life? Does it make you anxious? Does it make you feel safe?
IM06: It makes me feel safe. Because I know that if anything happens, that's really bad. I know there is an ambulance around the corner that's going to pick me up. That's okay. That waiting time is a problem. Because I'm losing quality of life. Without any hope of anything soon change. And especially without any knowledge of how long I have to keep on like this. If at

least I had a date in five years, then I'd say, okay, it's fine now. But at least you knew when it was going to come. I know what to expect. So it's a bit of an uncertainty. There is an uncertainty with the time frame. Which both make me anxious and less willing to seek for help. Because I know it's not coming early enough. Because it's not bad enough. If it's not bad enough, it feels like it's no point to seek help. Because it's not coming. Or it's coming, but in too long. It's coming at some point. But probably it's resolved by them. Or it's so much worse that I need more immediate help. And then I'll get to the legevakt, I suppose.
R: Is there anything that's not medical related that prevents you from seeking health care when you need it?
IM06: No. I speak Norwegian well enough.
R: Did you speak Norwegian when you first moved here?
IM06: A bit. I was able to converse a bit.
R: Have you felt that being able to speak Norwegian has helped you here? In regards to your medical needs?
IM06: It does help. It does help very much. I think in any situation, really. Doctors, just like any other human beings, don't like to have to express themselves in a language they're not trained to express themselves in. So I think I was... I think that was of great help. I actually have an anecdote for you on that matter. Just a few weeks ago, my sister-in-law, who is from Germany, and she was just visiting, so she doesn't speak a word of Norwegian. She's pregnant, and she had the feeling that she was losing the baby. So we rushed to the hospital. That's when I struggled to reach the legevakt. And we rushed to legevakt, and we got to that information counter. Where there is a primary person. That registers what's going on, and that will take your information. She didn't speak a word of Norwegian, and that lady in front did not speak English. Or she did speak English, but she didn't... She wasn't happy with it. Yeah. To have to speak English. You could see that she was... I could see that that wasn't what she wanted. But that was it. She had to. And she was saying that she was in the first trimester, that she had bleeding. That she was worried that she might be losing the child, that she wanted a check-up. And that lady said, well, you lost it, obviously. Without checking, and without any empathy, or nothing. No empathy, no checking. She was behind a window. She had no prior information about my sister-in-law. She had absolutely no gynecological training. She's probably a nurse. And she just bluntly told her, well, you've probably lost a kid now. Without any tact for a mother that could be going through a miscarriage. That's when I used mine Norwegian to say, that is not how you address a distressed mother in a horrible situation. And she looked at me a bit shocked, that I would name it. Like, really? But yeah, I thought that was one of the coldest things anyone's ever done. And I understand that you should be blunt in the medical system, but you should also be very reserved. When you do not have any information. You should have checked with people. Well, she didn't have any information. So when she said that, she just... Like, I saw that my sister-in-law got really, really distressed. And that could actually worsen her condition. It could create more stress. The child was okay. She did not lose that kid.
R: That's really good.
IM06: But that lady, like for a moment, made her think she had. Yeah. Because that lady across the counter had told her she had. So that was probably the worst medical encounter I've witnessed. It wasn't towards me. I would have burst into tears if anyone had said that to me. She's German, so she was really tough. But I would have been completely... I think any pregnant person in a different country and everything. Yeah. So that was not great. So language barrier. I hope she would have done better in Norwegian. I hope that she would have been more nuanced in Norwegian. But the English came really, really wrong. And it sounded very much like she just took a shortcut to avoid having to look for her words or anything. So language can be a barrier.

R: Yeah. Whoa. That's really really bad. Do you believe that being an immigrant has in any way impacted your medical treatment?
IM06: No. No. No. I don't think so. I have been very... I've been well treated. Yeah. I've been very well treated. I think maybe it helps that I speak Norwegian. Yeah. I'm more easily assimilated. But I do not feel like they have treated me any differently.
R: So you never felt discriminated based on your immigrant background at all here?
IM06: No. No, they were all very kind. And they were all asking, should we speak English? No, that's fine. So they respected. They asked if eventually I requested another language. I was never asked for a translator, but I never seemed to need one. Yeah. So... Especially if you're comfortable speaking Norwegian, it's... No, they were really... Yeah. I don't think anyone cared that I was from a different place.
R: That's really good. And is there anything else you want to mention about what you feel about the medical system here? Any comments? Anything else? Any comments?
IM06: I feel like the Egenandel is a bit rough on students. Yeah. Because I'm a student now, so I find it rough. But a few years ago, when I was an even poorer student, I know that it came to my mind when I wasn't feeling well. I thought, maybe I should call a doctor. And then I wondered, can I afford it? So it can be a challenge to students and to people that maybe don't have a good financial situation. I'm sure that someone who is employed and is doing okay, or someone with good parents, doesn't think about it. Yeah. But I think students and employed people actually think about it. So maybe they don't dare. Because I know I didn't. Yeah. At some point, I didn't dare to seek help.
R: Because there was Egendel?
IM06: Even if it’s like 250-280? Something like that. Yeah. So that's about 25 euros. That's half a day's work in France. It's still a considerable amount. It's actually a considerable amount. For someone without revenue, especially someone from a different country, that was rough. That was too much. Yeah. So I wish there was a green card for students. For students. People without any revenue. That they don't feel like they have to save for going to the doctor. Yeah. That's basically my only remark. Though I find Egendel very smart. Yeah. But mostly for people that can afford it.
R: That's pretty much it. Yeah. That's it. Thank you very much.

INTERVIEW IMMIGRANT 07

R: This is interview with immigrant 7. So just before you start, where are you from?
IM07: Philippines. From the Philippines.
R: And a little bit about your knowledge of the healthcare system here in Norway. Do you know how to properly seek out medical help?
IM07: Yeah, kind of.
R: Kind of? What are you unsure of?
IM07: It's like if you work, if you have actually the personal number here. Yeah. So you have the opportunity to go to the hospital. And you have your own doctor. Yeah. If you have the personal number. Because I came here as an au pair. Yeah. It was nice because I have the personal number right away. So they right away put some doctors for me.
IM07: Actually, no. But I don't use it much. Yeah. Because, yeah. Just I've been here like 11 years. But I just use it nowadays because I work too much. Yeah. It's actually easy understanding the, you just have to ask or they will help you anyways.

R: And when you first got here, did anyone explain to you how things work?
IM07: Actually, no. I just learned or meet some people that they tell how the healthcare here. So, no. It's like learning.
R: So you learned by doing?
IM07: By doing, yeah. There was no form or explanation of how it works, where to go or anything like that. No. It's like you just learn it when you need to it. So you learn new things.
R: And do you know which healthcare systems are available and how to reach each of them? Like dentist, Legevakt, health assistant, do you know what is available to you?
IM07: Yeah. But my doctor, so I can just go to my doctor. I can call my doctor. And then the nice thing with my doctor is, for example, if I get sick or I don't need to come there, I could have the electronic consultation.
R: So you like that option?
IM07: it's easier sometimes. But the thing is, Legevakt, I really don't know because you know, in Philippines, if you go to emergency room, right? You don't need to call the emergency room. You don't. If you're dying, you need just to go to the hospital, right? But here, you have to call. And I learned that because last week we went to the Legevakt. And I didn't know because who else will think of it if you're an immigrant, who will think of it that you will call the Legevakt. And you will ask for the time you will come there. And it's like, so I get scolded by them and said, OK, the next time I know it. And it was strange for me because I knew if you go to the emergency, it's emergency. You don't need to call. Right. So that's the thing. I was like, OK, why do I have to call? I am in the midst of something and then I do need to call them. I didn't know it.
R: So you kind of just learn things when they happen?
IM07: Yeah. There's no explanation or anything.
R: And what do you think about that? How does it make you feel? That you have to learn everything?
IM07: I think it's kinda bad, because you can't always know what's gonna happen and sometimes you might not have time to learn what you need before you need it.
R: True. And how long after you present symptoms do you usually seek out medical help?
IM07: Usually I don't seek medical help. If I knew I could still function without taking medicine, then I do that.
R: So you avoid seeking out medical help?
IM07: Yeah. Then after that, if I could. If you could still keep going, I don't look for help. I don't need help. So especially when I got the cough, you know, you really the good stuff. So I call doctor and then usually I called the doctor when I wanted to have a sick leave. Yeah. So that's one thing. So I only really seek out medical help if I had to do it because of my work. Because of work.
R: So you wouldn't seek out just because you need it?
IM07: Yes.
R: And were you like that in the Philippines or did that change after you came to Norway?
IM07: I've just always been like that.
R: And do you find it that is easy to seek out medical help here?
IM07: Actually, yes. Yeah. But sometimes, you know, it's not the same in our country that we can explain what we wanted and then they have like different stuff. Just go and take paracet. Yeah. Normal stuff.
R: And how do you feel that that difference? What do you think about it?
IM07: Sometimes I could say better because we don't need to pay if you really like hospital staff. We pay less. Yeah. But on the other hand, we need more. Yeah. Like we need more help. Not just like paracet or something.
R: So they need to be more proactive in their things?

IM07: Yeah, especially emergency. Why would we call it emergency? Before going there. I'm dying. I need to go emergency. I don't need to waste time trying to call and waiting for them to answer. Which can take a long time sometimes.
R: And a little bit about your relationship with your fastlege. Have you ever changed your fastlege here?
IM07: I actually didn't change. I had a first one when I came to Norway, but he was old. So they changed. So I just have it.
R: You just have the same one. And is your fastlege a men or women, if you're okay answering to that?
IM07: He's a man.
R: And do you trust him?
IM07: Yeah. He's actually a good doctor. Yeah. So I can't complain.
R: Do you feel that he hears you? Hears your complaints and take you seriously?
IM07: He does. Yeah. He's actually I really like. Is my husband has his own, but he never met. So that was different between my doctor and his doctor.
R: And do you feel comfortable sharing any type of information with your doctor that can affect your health?
IM07: Yes. Because I had already. I had the myoma. Yeah. So he helped me to put it to have some doctor. Uh, and then it helps that I actually like I knew it June. And then I got the operation like November. So that was fairly quick. They said around like six months, a year, you will wait with operation here waiting list. So I was lucky with that.
R: And is there anything you would like to change regarding your relationship with your fastlege?
IM07: No, actually, I kind of like it because there's my fastlege is in like a center. So that's really easy for me to have like a consultation sometimes. A little bit better.
R: And do you feel that the medical personnel here in Norway provides you enough information to make good and good decisions? Like, are they forthcoming with information? Or are you the one that has to seek out things?
IM07: I sometimes because I had one time accident, you need to have to tell them it's not like it's not like the same in Philippines, right? In my country that people there, the doctor will ask you, why are you here? Yeah. One time I came to the doctor and then I sit there and she did nothing. So I explained what happened to me. So, and then it's not the same doctor. It's like they always check in the, in the computer. What are you, what you have or what? Yeah. It's kind of strange for me. It's kind of strange that they have to check. Check in the internet.
R: And do you feel that you receive feedback about your health?
IM07: Sometimes. They asked us. So sometimes you can have offered that you can check it for free or something. So actually it was, it's okay. It's okay.
R: You think it's okay. And do you think you have a good amount of transparency about your medical information? Like you can access your results and your medical history. Do you think that's okay?
IM07: Yeah. I think yes. Because they, because when you go to fastlege, yeah. So it says there, and then especially in your health site, you see, it says there that when do you have been to doctor and what was your last appointment. What was done and everything.
R: And you have easy access to that. You know where to go and everything?
IM07: Yeah. That's right.
R: And, uh, is there anything that's not medical related that can prevent you from seeking out medical help?
IM07: Actually, no, because I know that they are really good in it. Yeah. They're, because if you really need, need help, then they will help you. But it was like, you know, the normal thing, a cough or something, then it like, just take this and that. But like what had happened to me,

they really like check it. And then they said, you can take it or you don't need it. But if you want it, we, we will put you already in the waiting list. So it was really fast.
R: So, in your opinion, when it's something a little bit more mild, not, not that big, it's a little bit more push the side, but if it's something very important, then they take it very seriously?
IM07: Yeah.
R: And do you believe that the medical treatment that you receive here is adequate to your needs?
IM07: Actually? Yes. Uh, when the operation I had, it was really good because they take it right away and then they really were really good at it. Yeah. And after that, I felt very cared for.
R: You felt that they really listened to you and it was very good for you?
IM07: It was.
R: In your perspective, how does the healthcare services here affect your everyday life? Does it hinder you from anything? Do you feel safe? Do you feel anxious?
IM07: I think it is safe for us, especially if you're working. Yeah. Uh, it is safe because you can, uh, access to your doctor. You can access there and you can have, you can ask medical or seek leave and something like that. So actually it's better. I really like it.
R: You really like it. You're happy with the, with the system here?
IM07: Yeah.
R: And do you think that being an immigrant has impacted your medical treatment in any way?
IM07: I don't think so because at the moment I don't need much doctor or something like that. But as I have, um, uh, I have a level of experience, um, they were really into, they were really into taking care of you for the big, the specialist is really good here.
R: And do you speak Norwegian?
IM07: Yeah.
R: Have you always spoken Norwegian since you've been living here?
IM07: No. I started talking Norwegian like after a year or something. Yeah.
R: Have you ever had to seek out medical care while not speaking Norwegian?
IM07: I never had.
IM07: No.
R: Norwegian. So you never had that barrier to your communication?
IM07: No. Some, some words because medical words are more difficult.
R: But you never experienced a language barrier to communicate with your doctor?
IM07: No. So if it, if I had difficulties, then I say it in English.
R: So that never been a problem?
IM07: No.
R: And have you ever felt discriminated based on being an immigrant by your fastlege or anyone else in the medical system?
IM07: Nothing. No.
R: Is there anything else you want to mention? Like any good experience, bad experience or anything?
IM07: No, just the only thing I was like disappointed with the emergency stuff. Yeah. That if you're really into emergency, you have to call them.
R: And how did they react to you going there without calling? Were they helpful? Did they mistreat you in any way?
IM07: She was a bit angry. Yeah. So it's like, you have to call. And I said, I really don't know that I have to call. It's the first time I had the, we had this situation. So next time I can do it.
R: But when you're in emergency and you met with someone that's angry that you're there, like, how does that make you feel that, you know?

IM07: It was really weird, of course. I think that it was like strange for me because I've been in my country. Emergency is emergency. Then you don't need to come there. You don't need to call. I never called emergency. The only thing you call is ambulance.
R: But for you, that was the only, the only part of the medical care here that you didn't like?
IM07: Yeah. And too much paracetamol. Too much paracetamol.
R: You think they, they were like too much paracetamol. Paracetamol is the most helpful thing they can give you. But overall you have a good experience with the healthcare system.
R: You never felt discriminated. You feel heard. You feel taken care of.
IM07: Yeah. I felt taken care of. Yeah. They were, it's good. You don't need to pay much. And then as I know that if you pay, if you pay like the amount, then they will give you, they will give you more that discount. Yeah. With the things you're buying, with the medical things. Yeah. After a certain amount, you receive a free card.
R: That's all the questions I had. Thank you.

INTERVIEW IMMIGRANT 08
R: This is interview with immigrant number eight. So just before we start, where are you from?
IM08: I'm from the Philippines.
R: And just a little bit about your knowledge of the healthcare system here. Do you know how to properly seek out medical help here?
IM08: Yes, I do. I think it's really easy. For me, I have good experience here. I have my medical condition.
R: So you know how to reach out to doctors and everything. Have you ever had any difficulties understanding how to use the medical services available?
IM08: No. For me, I have a nice experience because I don't have difficulties about it. My fastlege is really good, so I just know I need to go to him and then he will do what needs to be done.
R: And do you know what healthcare systems are available and how to reach all of them? Like about health system?
IM08: Yes, I feel like I'm very aware of everything.
R: When you first got here, did you receive any type of information about how the medical system here works?
IM08: I think, yeah, because I come here as an au pair. I think I received a lot of papers about it, but I did not read everything.
R: Yeah, you didn't read everything, but you received some papers that you think explained everything?
IM08: Yeah, that was helpful. Yeah, I received everything.
R: So you received everything, but nobody came and explained it to you. It was just a paper?
IM08: No, it was just the papers.
R: And was it the paper in Norwegian, English, or another language, do you remember?
IM08: I think it was in Norwegian.
R: It was in Norwegian. So you had someone translate it to you, or did you speak the language?
IM08: Yeah, I asked my boss about it.
R: So your boss helped you understand it?
IM08: Yes, he did.
R: And how long after you present symptoms do you usually seek out medical help?
IM08: When I arrive here as an au pair, I have something problem with my skin. I go to my fastlege, and then later he refer me to the dermatologist. But everything is going well.

R: Yeah, but when you present symptoms, how many days or weeks do you go for medical help? Do you wait a few days? Do you wait a week?
IM08: I think I wait for a few weeks, because I go to my fastlege like three times, but he didn't give me medicine or something. That's why I asked... In the third time I asked him about... He need to refer me to the dermatologist.
R: So you had to request to be sent forward, like they didn't do it by themselves.
IM08: Yeah.
R: Do you find that it's easy to seek medical help here?
IM08: Yeah.
R: You've never had any difficulties?
IM08: No.
R: But do you feel like you have to advocate for yourself? Or have the doctors always been good at referring you and everything?
IM08: They help me a lot.
R: They help you quite a bit?
IM08: Yeah.
R: So you trust your fastlege?
IM08: Yeah, I really like him.
R: If it's okay with you, is your fastlege a man or a woman?
IM08: It's a man. And have you ever changed your fastlege?
R: Because he is old. And now he retired, and now I have a new one.
R: Yeah, so that's the only reason why you changed?
IM08: Yes.
R: And do you trust your new doctor?
IM08: Yeah.
R: You think he's a good doctor?
IM08: Yeah.
R: Does he hear you? Do you feel that he hears your concerns and everything?
IM08: Yeah. So I tell him everything, so he helps me a lot.
R: So you feel very comfortable sharing any type of information with him?
IM08: Yeah.
R: And is there anything that you would like to change regarding your relationship with your fastlege?
IM08: No. I like him. He's nice.
R: You feel like he's very good, he cares for you and everything?
IM08: Yeah.
R: And do you feel like people here in the medical field, do you feel that they give you enough information so that you can make good decisions about your treatment and your health?
IM08: Yeah. I think so. I think my fastlege is really good with that.
R: You feel like they're very good in that sense?
IM08:Yeah.
R: And do you think you receive enough feedback about what's happening with your health? Like something happened, you were able to see results, and they check on you?
IM08: Yeah. Yeah, I've always had good input.
R: And do you feel like you have transparency regarding your medical data? Like you can access your data, you can access your information and everything easily, you know where to go?
IM08: Yeah. I can log into my helsenorge.
R: In helsenorge?
IM08: Yes.

R: So it's very easy for you to navigate the system?
IM08: Yeah.
R: And do you think that the medical treatment you receive is adequate to your needs here?
IM08: Yeah.
R: You've never had any issues, never problems?
IM08: No.
R: And how do you think that the healthcare systems here affect your everyday life? Do they make you feel safe?
IM08: Yeah, I feel safe here because I have a lot of experience in the Philippines, but because my eldest, Alessandro, he was born in the Philippines, but Helena is here, so I feel safe here. I can feel that I have all I need.
R: Yeah, you feel much safer here?
IM08: Yeah, much safer, yeah, because I have complications with my pregnancy then I've been in hospital for 22 days.
R: Yeah, that's a long time.
IM08: Yeah, it's a long time, but I feel safe in the hospital. Yeah. So, thanks God she stay until 35 weeks.
R: That's very good. Very good, young lady. And is there anything that's not medical-related that can prevent you from seeking medical care when you need it?
IM08: Um, yeah. If I don't have anyone to watch the kids I think. Yeah, so they come first beforeBut I'm really happy about the medical care here.
R: And do you speak Norwegian?
IM08: A little bit. A little bit. But especially, for example, if I've been in the doctor or something, I really want English so that I will understand everything.
R: You prefer English. And have you ever felt that that was a difficulty for the doctor to understand you?
IM08: No, because if I ask if English, they can, yeah, they are good in English.
R: They are very good in English as well, so it's never been a barrier for you to get medical care here.
IM08: No.
R: And do you believe that being an immigrant has impacted your medical treatment in any way?
IM08: No. No. I did not feel that way.
R: Have you ever felt discriminated for being an immigrant here when seeking out medical care or anything?
IM08: No.
R: But that's it. Do you have anything else you would like to mention or experiences, bad experiences?
IM08: No, I have good experiences here. I'm very happy.
R: Yeah, that's it. Thank you very much.

INTERVIEW NORWEGIAN 01

R: Alright, so now we're recording so just so I know Norwegian one thank you again for helping me so I'm just trying to figure out how you feel about the health care here in Norway so I have like a few questions and then we can have a little conversation as well so the first thing is like how is your knowledge of the health care system here in Norway like do you know how to properly seek out medical medical help
NO01: Yes, you can go to your fastlege. I'm using my fastlege.
R: so you know like where to go to get the proper medical care that you need
NO01: yeah yeah
R: and like have you ever had any difficulties understanding which medical service you should contact ?
NO01: at that moment there was I was sick before Christmas yeah with the crystal sick yeah and it was very acute yeah and then I go to the doctor
R: yeah you went to the doctor?
NO01: yes
R: you sought out the doctor ?
NO01: yeah and they said that this is a problem I should take to my doctor yeah but I thought I was you're you're supposed to go there because it was like it felt like an emergency yeah because I couldn't walk and but it's not always easy to get contact with fastly yeah because he has other people patients yeah and sometimes he apparently like works on the computer yeah and have days where he just does that so then I can't come into him I have to go to another doctor so it's not so easy to get in contact with him sometimes yeah so it seems easier to like go to the like to the emergency yeah and well I think this one kind of ties up to that one like
R: do you know which health care systems are available and how to reach them?
NO: yeah yeah you can't always always just like go to the emergency room like you have to call yeah yeah most of the time most of the time they say that it's not like don't it's not with us yeah it's like it's not serious enough yes take some painkillers and maybe it will go over.
R: so you say that like sometimes you're a bit unsure if you should go to the emergency or to your fast like it?
NO01: yeah and it seems like like you it's almost like you have to almost die to be able to that the emergency room is going to take you in yeah like if you feel like there's been many times we have had to call the emergency room because I was so so sick and it's like in the middle of the night and they in the sleeping and they're just nobody just take some painkillers it it will probably go away and then like this happened when I was very young and they wanted to send me home from the emergency room but then there was a doctor who like came walking and because it was my eye it was blue and leaved fast I couldn't open my eye yeah but there was like one doctor was like stop I want to see on this eye a little bit more and he took me serious and I ended up in the hospital and if they hadn't if they didn't take me if they didn't have done the exams and everything like that if they hadn't my English if they hadn't if they didn't take if they didn't if they hadn't taken me in yeah
R: they hadn't put it put you in the hospital
NO01: yeah I would become blind so it was very good that that one doctor had no stop she's not going home
R: so you got very lucky in a way but the emergency room said no go home take a pill take a paracet
NO01: yeah so this was customary till it seems like it has to be dead serious if you're not taking so it's very high school yeah it's very well yeah it just has to be almost life and that yeah I'm going to go to the emergency room like you but I just don't care yeah well it has to be like obvious life and that because like almost going blind is quite serious
R: yeah but they couldn't see
NO01: yeah

R: so unless it's very obvious that it's life and death they just kind of dismiss it in your in your perspective?
NO01: yeah yeah yeah
R: that really sucks I'm really sorry that happened to you and like all right so this is about how you seek out medical care like how long after presenting symptoms yeah usually go to the doctor
NO01: I suffer from hypochondria yeah yeah when I was younger I wasn't as bad but now if like I'm not very sick this got to me till it's not if not that's like I call fast like in very fast
R: yeah any symptom that you present that you know you're getting sick that's not normal?
NO01: yeah like I can feel it I can feel it it's the flu yeah that's okay but more than that then I get the word
R: yeah you get worried and your first you call the fast like right away
NO01: yeah like if I'm feeling dizzy over like four days that I'm like hello if you've been dizzy for four days you should seek out the doctor like if it's like one day then yeah I try to push my limits yeah just like okay I have to wait one more day and if it hasn't stopped then I can come
R: so you wait a little bit before looking out and do you find it easy to seek out medical medical care?
NO01: here like it's easy but like we have something called the patient cheap mm-hmm which is kind of a dead the app yeah and then you have to like pick an hour and he hasn't many hours yeah and it's like many days until and sometimes I need to come in instantly yeah and that can be very hard to get because like he's not always at the office and like every time I've called with this when I had to stop seeking now and like every time I call he isn't here today but we can set you up with this person so it's easy to find it but it's just hard to actually get there
R: yeah and is there any type of external factor that prevents you from seeking medical care when you're in need of it like you're afraid of having no money to pay for it or like your job or it might affect your school is anything that's not medical related?
NO01: that yeah if it's like if it's like if it's like if I have school yeah I'm not from I'm not probably like skipping a class if I can get an hour with the doctor with the doctor like I need it
R: yeah so you feel like it's better to prioritize the
NO01: yeah if I can yeah
R: okay so this next part is a bit about your relationship with your fast leg and you mentioned that you've been in Christiansen for a few years I just want to know was it easy to change your fast leg it from Oslo to Christiansen
NO01: yes there was a website and you can like there's a list of fast leg you can choose and some have like long waiting lists and some don't yeah and when I was going to change there wasn't many left and I found him and he didn't have a waiting list and he's very I think he is newly educated
R: oh okay he's very young ?
NO01: yeah so I think maybe that's why he didn't have a lot of patience
R: yeah and just because this is something as well is your fast leg a man or woman
NO01: yeah
R: and do you trust him?
NO01: yes I feel like I have like you have to trust the doctor because they have an education yeah kind of but I don't feel like we have a real like a solid relationship yeah kind of yeah
R: so like you trust the doctor but not necessarily your doctor ?
NO01: yeah just like the fact that he is a doctor yeah so I just believe everything he says kind of yeah yeah
R: and uh do you feel comfortable sharing any type of information that could affect your health and treatment with him?
NO01: yeah

R: you don't have any problem?
NO01: I like I have a tendency to just like talk very much
R: so so you're very open about it so he knows like he gets to hear everything
NO01: I'm thinking about yeah
R: that's good and you feel like he hears you he hears your concerns and yeah
NO01: I have a tendency in my head to like make things bigger yeah they maybe are and he's he seems very realistic but I feel like he he takes me seriously yeah but I have like I have when I have been to other doctors here because he hasn't been in and they have been with women and they have like it seems like they get the problem more even though they're not specifically it's not because we're both the women no it's like about general disease yeah things but it's like they they take me more like oh let's take this problem
R: they take your problem a little bit more hands-on
NO01: yeah a little bit more seriously yeah like but he's like more like chill yeah more relaxed more let's wait and see yeah this it can be this it can be this but probably not I will set you up with this and if it doesn't go over you can take out this recept but the women are more like hands-on like okay we fix this problem now
R: yeah so you feel like he he lets it kind of flow a little bit more and how do you feel about that?
NO01: like kind of I prefer the ones who take me more hands-on yeah because I like to be fixed yeah
R: you don't like to be sick?
NO01: yeah I don't like to wait and see yeah kind of yeah yeah
R: I don't think many people do with their health you know and is there anything that you would like to change in your relationship with your fast like it ?
NO01: like I'm moving in like four months yeah so I have to change for instance
R: like you just mentioned like maybe you would like him to be a little more hands-on yeah like be a little bit more preventive be a little bit more all right so this is your symptom we're gonna figure out what is wrong
NO01: yeah and I feel like he's more how to explain it I feel like I kind of have a more better relations with the women that I have been with yeah and I feel like they almost know me yeah on a personal level even though I haven't you have a bigger connection with them
R: yeah then you had with your doctor
NO01: yeah because he's more like he sees me as a patient mm-hmm kind of while the women see me as a person kind of a whole person yeah but it seems like for him I'm just like a patient
R: so in a way he sees you more like it's sure that he just kind of has to get done and kind of and like
NO01: yeah he has just been for like three years yeah so he doesn't know me so well mm-hmm but the women it seems like they know me very well and never met them one time so it's like maybe I will change
R: that kind of so does that make you want to make maybe you have a woman fast like it
NO01: yeah and I had a woman's last idea before I was here and she was also wearing a handsome and she know she knew the whole me yeah kind of both the physical and the psychological yeah
R: so she understood you a little bit more
NO01: yeah and then I find it's maybe easier to find out the problem as well yeah yeah
R: it helps and so this is a little bit about like how does the medical services impact your everyday life do you believe that the medical treatment that you receive it's adequate to your needs like you when you seek out medical care or medical treatment or anything like that do you think that the treatment that they give you is adequate to what you actually need?
NO01: yeah that they're doing the right thing

R: yeah the treatment that they give you yeah is it adequate for you
NO01: I think so yeah yeah
R: so but for instance like you mentioned that he takes a little bit longer on your treatment so like yeah but you end up getting there
NO01: yeah yeah just the longer process kind of mm-hmm
R: and do you think that uh well in your perspective like how does health care services here affect your everyday life
NO01: that one's a bit harder can you give me an example
R: like do you feel safe seeking out medical care to do anything in your everyday life or are you afraid of doing something because you might need medical attention and you're not sure how to get it kind of like
NO01: I'm not afraid to do something in case I need medical help but I'm always afraid to get sick just because like the emergency room yeah it's like it's life or death or you go away yeah I'm going to take in like and then it gets gets more difficult to kind of reach out because I'm just going to get you're just gonna be dismissed yeah yeah
R: so so your main issue is more with the leg evoked then with the actual fast like it
NO01: yeah like I'm not it's not like I limit myself to do something just because
R: yeah but you have a small insecurity
NO01: yeah about that yeah especially with like the emergency room yeah
R: and is there anything that's not medical related that can maybe prevent you from seeking health care treatment if you ever need it like I don't know maybe someone will prevent you or anything else in your life that can stop you from seeking out medical care
NO01: I feel like I seek medical care help if I need it yeah there's nothing like not that I can think of right now at least yeah yeah
R: sometimes there's nothing that sometimes you feel very safe and yeah
NO01: I feel like I I trust even though I'm not happy with the emergency room I kind of trust what they do when like if they take me in or if a slaying takes me and I trust what they tell me about my health condition because I've put a lot of trust in the fact that they have studied medicine and and who else am I gonna trust them I can't trust myself I don't know what's happening in my body
R: so I even though you have a little bit of insecurity about the level they have to be to seek out the emergency room or you wish that your doctor maybe be a little bit more hands-on you still have a lot of trust in the system
NO01: yeah
R: and everything yeah and like if there was anything that you could maybe change to improve your fast leg or the emergency systems or the system as a whole like what would you think could be an improvement
NO01: like me like me personally I think that they should take this more seriously but I also understand that they have a lot of people coming in yeah I understand that like my crystal CK is not as important as someone who has been shot in the heart yeah and they have like they have so so many people available to work and they don't have the capacity to take everyone and I understand at the same time I think they should like find kind of some solution yeah because every illness is important even though they're not like definitely
R: yeah so you would like them to be a bit more a mindful of everyone in a way
NO01: and it's like it's unfair but at the same time it's fair like my my grandma now she had she broke her arm yesterday and she was going to get surgery today but then they couldn't do this surgery today because something important had happened and they had to prioritize to have a surgery on someone else and like I understand because maybe that's life or death and my grandma is not dying she has just a broken arm it's like she's still a patient and you kind of

promised her to take the surgery today and then you just back out and I don't like that even though I understand
R: yeah like you understand it but you don't necessarily agree with it like you
NO01: yeah they should have like more people like so they can take in more people and actually do what they have to do mm-hmm
R: it seems like they're short on people and there's a lot of like seeking yeah can't work and they're very short on staff but that's a lot of them there's so much that there's music in
NO01: yeah yeah a lot of things that play a part in so I understand but I want to change at the same time
R: yeah that makes sense is there anything else you want to comment about like how do you feel about your healthcare system here how do you feel like you feel heard you feel safe you feel comfortable anything else that you might want to talk about from your perspective and your life experiences like
NO01: I like I said I feel very safe but I wish they took people more seriously and like every time I get ill I feel like I have to go to either emergency room or especially the emergency room like I always get a bad feeling when I feel very sick I guess oh they're probably going to dismiss me and it makes it harder to like reach out yeah the next time and maybe next time it's extremely serious and then maybe I die because I didn't you didn't feel comfortable enough seeking it out yeah
R: and just a final question but do you feel like being a woman has any impact on that on being heard or being taken seriously
NO01: I don't know because you hear a lot about it mm-hmm and they're like I haven't like I'm not the man yeah I haven't felt like I haven't been able to feel how from a man's perspective
R: how from your perspective as a woman do you feel that maybe they take you less seriously because you're a woman or
NO01: I keep thinking like that but I have like no I haven't like when when I've talked to like guys and yeah their experience like a lot of them it's also feels like they're not taking seriously
R: yeah so it feels to you that is more like a general thing
NO01: yeah actually but like there's a lot of talk in society that women are treated differently but I haven't I'm not sitting on that feeling yeah I'm like in general it's like so it's bad for everyone you know yeah it's like it's not that serious yeah take a pot of said yeah it's not like it's just guys that are getting help at the emergency room yeah I think it's a more general thing yeah
R: all right that is it thank you very much I'm just gonna stop recording

INTERVIEW NORWEGIAN 02
R: It's recording and then this is interview with Norwegian 2. Hi. So, we're going to start a little bit about your knowledge of the healthcare system here in Norway. Like, do you know how to properly seek out medical care here?
NO02: I would contact my fastlege. That's the way I would go. I don't know much more than that because they will refer me if I need anything.
R: Yeah, so for you basically you just go to your fastlege and from there you do anything?
NO02: Yeah.
R: And have you ever had any difficulties understanding how to properly use the medical services that are available?
NO02: No, not really. I find them quite easy to understand. They are well explained and now that they started doing a lot of things digitally as well, it's easier to get in contact with them than it was earlier where you had to call them. So, I feel like I'm getting my way around it.
R:Yeah, you feel like it's very easy. And do you know which healthcare systems are available and how to reach them?

NO02: Not necessary because I do everything through my fastlege basically. So, I don't know much outside of that. They say you need to be referred there, go there, you go there. So I don't know much about the healthcare system in general, but it's working.
R: Yeah, so for you, you just go to the fastlege and from there everything kind of solves itself.
NO02: And then also sometimes you feel like I need to go somewhere and then you talk to your fastlege and say I want to be referred to this or that. And then sometimes they do, sometimes they don't.
R: And if you needed any other type of healthcare system that is not provided by your fastlege or if you want a second opinion or something like that, do you know how to go about that? Do you know if it's available somewhere?
NO02: Yes, you always have Google that can help you with things like that. We have or I have been in private hospitals because it would take me too much time going through the official system. So it was easier to contact a private hospital and say can you help me with this problem and then go in there. But then I think we just Googled.
R: So for you the only real reason to go through a private healthcare would be the amount of time that would take.
NO02: Yeah, because that was for injuries that you know that they don't prioritize as much in the official one because you need to be quite sick or it needs to be a big injury. But if it's like smaller things that you know can be fixed, then you know you will get pushed back in line. So at that point it was easier to just go to the private one. And pay, unfortunately.
R: Yeah. And okay, this is a little bit about how you go about seeking medical care. How long after you present symptoms do you usually seek out medical care?
NO02: I'm not very good at going to the doctor at all, unfortunately. So I normally tend to take a couple of days too long sometimes. But it depends on what it is. If I just feel a bit sick or something, I normally don't contact them. So I feel like it must be a bit more serious before I ask them for help. But after I started working full time, you'll figure that it's easier to contact them about smaller things because you need to know that you can get the egenmelding or the doctor’s note to be able to get time off work. But I have not been the best at going there early, if there’s anything.
R: Do you think there's any reason for that? Or is it just you don't like going to the doctor? Or you just...
NO02: No, it's just that I'm stubborn. And I think that I can fix things on my own. So I don't always see the reason why to go there. If there's just like you have a sore throat or something, I don't see the reason why to bother them. Yeah. Unless I feel like it's, oh, it doesn't get better. It must be something else. I always think, can I fix it myself first? And then you try that a couple of, two, three, four times and then, okay, now I'll finally go there. But it's not that I don't like them or anything. It's just I'm stubborn. It's just a personal choice. Yeah, just a personal choice.
R: And do you find that that is easy to seek out medical care?
NO02: Sometimes yes, sometimes no. It depends on what is wrong. Because sometimes it's like, okay, this is okay to go to the doctor with. But other times I can feel like it's like, I don't want to bother the doctor about this because it can't be nothing. But after they got the digital patient app thing, then you can go in and just see, okay, my doctor has an available time tomorrow at whatever time. And then it's easier to book that time instead of earlier when you had to call them and say, oh, can I talk to the doctor? I want to have an appointment because of this and that, because I don't feel like I have to explain as much before going in there. So the fact that you can just go in and see if it's available, it makes... Made it easier for myself.
R: Yeah. And is there anything non-medical related that can prevent you from seeking medical care when you need it?
NO02: No, I don't think so.

R: Just your stubbornness.
NO02: Yeah. Basically. I've become better during the years. But yeah, no. If I feel there's a need, I'll go there.
R: And now we're going to talk a little bit about your relationship with your first leg. First of all, if you're comfortable sharing, is your first leg a man or a woman?
NO02: He's a man. It's kind of interesting that I've only gotten male fastlege so far.
R: And do you trust him?
NO02: Yes, definitely. I've had him now since I moved here, so that's 12 years. So yeah, I trust him. It's so wild to have the same doctor.
R: Do you feel comfortable sharing any type of information that could affect your health and treatment with him?
NO02: Now I do. In the beginning, no. Because I felt in the beginning, moving here at 18, being a girl going to a male doctor, it wasn't too easy to talk about private things. But as I get older and you get a more connection with your doctor, it's easier to talk about basically anything when you get that relationship. So, but I...
R: So it was a relationship that was built over time.
NO02: Yeah, I would say so.
R: And do you feel that he hears you when you have concerns?
NO02: Not all the time. Most times, yes. But I have been there times where I've specifically asked to be referred on because of the family history with illnesses and stuff. And I was told that you're too young to get that disease, or you're too young for this. And I was stubborn again. And I didn't quit, so eventually it's like, okay, I'll let you do it. But at that time, I felt like he wouldn't listen to me. Yeah. So, but it's been on and off. Yeah. But I've stayed with him.
R: How does that make you feel, like when he doesn't hear your concerns?
NO02: I was really upset with that. So I have actually asked to transfer a doctor now. So I'm on a waiting list for a new doctor, but that's also because we have moved and it's easier. But at that point, when he didn't listen to me, I was quite quick to look after a new doctor.
R: Because you feel like the bond you build up has been broken.
NO02: Yeah. Because you trust them and you trust them to help you no matter what. And then you come and you say this and that, and they're like, no, that doesn't occur to you. And then, it does after all. Yeah. So, yeah.
R: So the fact that he kind of dismissed you was a very big...
NO02: Yeah,
R: because you feel like there's a trust that's not there anymore.
NO02: Yeah,
R: and how are you going to have a doctor if you don't trust the doctor?
NO02: Yeah. And then, so, most of the times it's been really good, but that one thing I felt was not okay at all. Yeah. So, yeah. I'm going to get all the little paws in the recording. Sorry.
R: Well, and then I think this one is like, is there anything that you would like to change regarding your relationship with your fast leg?
NO02: Well, the only thing would be that he actually listens to everything, not only what he feels is best. Just come and sit that way. Yeah.
R: So basically what you would like to change is you want your fast leg to take you more seriously, your concerns more seriously
NO02: Yeah, because normally you don't have concerns without a reason. And in my case it was that a lot of people in my family have the same disease, so I want to be checked.
R: Of course. Because you want to be sure that there's nothing wrong.
NO02: And then when you... Because I think I was 23 at that point. And when they say, but you're too young to get this disease. You're never too young.
R: No, you're never too young.

NO02: And if you would have given me another reason, I might have said, okay. But when you give the reason you're too young, it's... Yeah, the trust was broken quite easily, unfortunately. So I wish I could take, but I feel that might have been because he's a man, I'm a woman. And it's, yeah, girl problems.
R: Yeah, so you think the fact that you were a woman was one of the reasons why he didn't take you as serious.
NO02: On that point, yes. Yeah. Yeah, actually, unfortunately. I mean, it is what it is, unfortunately. I can't say for sure, but... That's what it felt like.
R: Yeah, that's kind of what I want to know.
NO02: It's impossible to know exactly what it was, but... But that's how it felt to me.
R: Yeah. That's really bad. I'm really sorry.
NO02: It's okay.
R: And a little bit about the impact on your everyday life. Do you think that the medical treatment that you receive here is adequate to what you need?
NO02: Yes, I think we have a really good healthcare system in general that you're being referred on to people that know more than the fast leg. Because they know a tiny bit about everything. And then you're being sent to specialists that know more and to the correct place in the system. So I'm not afraid that I wouldn't get the correct treatment. But then again, they do have systems within the systems that are not working. And they do have systems they need to fix. So... But I'm not afraid that I wouldn't get the proper care, no.
R: Yeah. And do you think that... Because you get referred to a specialist and the time that it takes to see the specialist... Do you think that it's good as well?
NO02: Yeah, and I think that depends on what's wrong with you. If it's like... I don't know, say something with your muscles for example. You might be put back because it's not as serious. But if it's a serious disease, you get referred really quickly. And I know that they have time limits. That if this and this happens, you have to see a specialist within so and so many days. And they're very strict about those days. So I think that's very good that you get... Things happen quickly. Yeah. If needed, if it's necessary. But if it's more like... You can have this for a long time without it being a big problem in your life, you will be put back. So... Yeah. Depends on the situation. Depends on the level of the... Level of seriousness of injury or illness or... yeah.
R: And in your perspective, how does the healthcare services here affect your everyday life?
NO02: Well... Quite a lot. Quite a lot. But... Yeah, I'm not quite sure how to answer that question actually. Because... To know that you can get help right away is very important. And to know that if you call Läkevakt or the ambulance for example, that you get people that... Know what they're working with. So they know how to help you. It's really comforting knowing that if I do make that call, I will get the help I need. Especially if you look at other countries where you hear that they don't have a good healthcare system. And all of that. And that makes me really appreciate what we have here. And also of course that we don't have to pay much for it. So you don't have to worry that if you actually end up in the hospital, you don't have to worry about the economy and how to pay for all of this. You won't go bankrupt like in the States or something. Yeah. And so it does affect you to know that it's there if you need it. It gives you a sense of security in a way. Yeah. I can't go to the doctor because it will cost me too much. Or I don't want to make the call because I'm not sure if they know what they're talking about.
R: Yeah. So you have a good reliability in the healthcare system here in your opinion. And this one is a bit repetitive. Is there anything that's not medical related that can prevent you from seeking healthcare?
NO02: No. It must be or it could be being afraid of making the call. Because I have thought about that sometimes. If something would happen, will I dare to make the call to the ambulance

for example? Do I know if it's serious enough? But I think I would do it anyway because we're trained to do it. Basically through my job and through volunteering with the hospital. And through work and everything. So I don't think there's anything that would prevent me to take contact. But I think a lot of people are scared of making the call. Because they don't know what will meet them. And that's understandable. I've thought about that myself. What would I do if I come to an accident or if something happens with a person on the street or something. Would you make the call right away? But I think it's automatic.
R: Yeah. And have you ever, being a woman, you talked a little bit about how you felt that your doctor didn't hear you a bit. Was that something that happened only with the FHL? Or has that happened other times?
NO02: No, only with that. Because when I then were referred to the proper people, I met both male and female doctors. And they've been great.
R: And they've been great at taking you seriously about everything basically. So it's only the first time that I...
NO02: It was just one very bad experience. Yeah, with him. And then as long as he eventually did it. And then I was passed on to great people actually.
R: So the only real problem is that he's sort of the gatekeeper?
NO02: Yeah, at that point he was. So that's also a bit of why I want to have a new doctor. And now I want to have a female doctor.
R: So as you get older you understand that it's a bit more different things happening.
NO02: Yeah, sometimes it's nicer.
R: Is there anything else you want to talk about? Like about how you feel about the healthcare system here? Anything you want to share about something that was really good or was really bad?
NO02: Only in Kristiansand? Or in general?
R: In Kristiansand.
NO02: I think everything here has been great. Having been in and out of hospital a few times. I've met a lot of great doctors at the hospital. At the medical centers around. And they seem to really know what they're doing. I've tried it other places in Norway where it didn't work as well. So I'm very comfortable having the doctors and the nurses and everything down here. I feel like they're doing things in a really good way.
R: And they make you feel safe?
NO02: Yeah, they make you feel safe.
R: They make you feel heard?
NO02: Yeah, because I've experienced other places where it's not as comfortable as down here. So I don't think I would ever be afraid of seeing a doctor here or anything. And they listen to me. So I think they're doing a good job here. Yeah, they are.
R: That was about the questions I had. I'm just gonna end it now.

INTERVIEW NORWEGIAN 03

R: So now we're recording so this is Norwegian 3 interview and I'm just starting a little bit broad like your knowledge of the health care system like do you know how to seek out medical help here?

NO03: Yes I do. It's I call my fastlege and if I need any further treatments he refers me to whatever I would need like ER or the hospital or yeah.

R: So you basically just go to your fastlege and he will take you further if you need it. And have you ever had any difficulties understanding how to use the medical services available to you?

NO03: No, no really and if there is anything I don't understand then again I have a very good fastlege so he's always helped me with you know yeah any questions that I have.

R: Yeah so it's always been easy for you to get that done. And do you know which health care services are available and how to reach them?

NO03: Most of them yes and I can also use HelseNorge, the app that also shows basically what I what is available and that you can choose which hospital you want to be treated in if you need a hospital treatment.

R: So you feel very comfortable navigating the health care system you think is very easy to get around?

NO03: Yeah for me it is.

R: And how long after you present symptoms do you usually seek out your fastlege?

NO03: Well with all that's going on in my body I do it very quickly. It's kind of a day or two after I start feeling sick or have any symptoms of anything then I contact my fastlege.

R: So you're very proactive when looking for medical help. And do you think it's easy to seek out medical help?

NO03: At the moment my fastlege has very, he has too many patients if you ask me. So from when I order an appointment with him it can take up to a month before I get an appointment. But apart from that it's okay.

R: How do you feel about maybe having to wait for a month before you can get?

NO03: It's not always easy. It all depends on what's wrong if you know what I mean. It could be something simple or it could be something that you have no idea what it is. Yeah and if it is something I know then if it's not serious then it doesn't bother me to wait really. But if it's something that I don't know what it is, if it's something new then I normally call the office and say how I feel about it. And then sometimes they have some emergency appointments.

R: Yeah they can fit you in a bit earlier. So when you feel a bit anxious about the time that it can take you usually are a little bit more pushy about trying to get an earlier appointment.

NO03: And that is also because of my medical history with cancer. My doctor knows I'm anxious so he always tries to fit me in if there's a long waiting list.

R: So he's very good at accommodating you in a sense.

NO03: But not all doctors are that. You're just... I'm lucky to have a good first leg.

R: So you have seen other people that don't have the same as you.

NO03: Yeah. Yeah.

R: And is there anything that's an external factor that can prevent you from seeking medical care when you're in need of like I don't know afraid of paying or time that it's going to take feeling like you're going to be bothering the first leg.

NO03: No not really not that I know of.

R: Yeah so you can't think of anything that can stop you from seeking medical care.

NO03: Well yeah that would be if I don't have the money to pay for the doctor. Because you have to pay the egnandel up to a certain amount. But being on UFØR, medication is or medical help and medication is not always easy especially like the first two or three months a year. Until I get the free card. But with me traveling to Oslo once a year to the cancer hospital by

March I do have the free card. So even though the egnandel is not a high amount it's still a significant amount that can prevent you from seeking help unless you feel like it's absolutely necessary.
R: That's interesting because it's quite a few people that have mentioned that the egnandel can be like.
NO03: Yeah and it's going up and up and up every year. You know you have to. Yeah I know. Use more before you get the. The free card.
R: Yeah and it's different right the egnandel for doctor and the egnandel for medication.
NO03: No that's on the same. That's on the same as the physiotherapy that's. That's the different one because I know there's there's two egnandels that are separate.
R: Tanlege used to be a different one.
NO03: Yeah now it's. That is on the same as well. So I think everything is. It's becoming the same. It's becoming the same yeah and that's why. It's going up. Yeah. So there's changes happening too. And yeah.
R: And then a little bit about your relationship with your fast leg it like you mentioned it's a it's a guide right as a male doctor. And do you trust him.
NO03: Yes I do. Yeah. And yeah. 100 percent.
R: Yeah. And has that trust been built from a long relationship or have you always like from the beginning trusted him.
NO03: I lived in Liverpool and when I came back in 2010 and helpful provided me with him as my first leg. Yeah. And from the first day I met him I've trusted him. Yeah. And he's helped me from the first day. So it's. Yeah.
R: So you've always had a very good relationship with him.
NO03: Yeah. Yeah.
R: And do you feel comfortable sharing any type of information that could affect your health and treatment with your fast leg.
NO03: Yeah. Yeah.
R: And do you have anything.
NO03: No.
R: That could affect you.
NO03: No.
R: And do you feel like he hears you.
NO03: Oh yeah.
R: Your concerns and everything.
NO03: Yeah. And yeah. He when when I went for an MR in 2016 of my hips and they found a lump in my tailbone and at first my doctor said well it's that's tiny I don't really know what it is but I can see you are kind of nervous and anxious so I will send it off to the hospital in Oslo and then you know we await an answer from there. So yeah it's.
R: Yeah. So you just feel that he always takes your not just what you're saying but how you're feeling into consideration as well. And have you ever had a problem with information like do you feel like your fast leg and the other health care systems that you've been here. Do they give you enough information. Do they give you enough feedback.
NO03: My first leg it does and the cancer hospital does but like the ER and the hospital here in Christiansen I don't feel they are as good. Because I think they have too many patients coming in. They don't have time to deal with you properly if you know what I mean. So it's.
R: So you feel it's more it's not necessarily a problem of the it's a problem of the amount of patients and not enough staff. That creates like a disruption in the communication. And it's something that could be improved maybe. And is there anything that you would like to change regarding your relationship with your fast leg. That he didn't have so many patients.
NO03: That would be the. Yeah. Yeah.

R: Apart from that there's nothing I would change. So you just it once again comes to the staffing issue. You would just wish that there were more doctors in more doctors available. For everyone.
NO03: Yeah. Yeah.
R: I think it's a problem of your fast leg because my fast leg is also the same. I think most of them are.
NO03: Yeah I think so. There's not enough doctors.
R: No I feel like it's a very common issue here. Not just doctors but nurses.
NO03: Yeah medical care. Medical workers.
R: Yes. Yes. As a whole. And do you believe that the medical treatment you receive is adequate to your needs here.
NO03: Yeah. Yeah.
R: You've never had an issue that wasn't solved or that was. That maybe took too long to solve.
NO03: There has been one one issue that's been going on since 2013. But what they are doing is the only way they can do it. It's just like time consuming. It takes time. Yeah. To fix it.
R: Yeah. So. So you feel like it's adequate. It's just sometimes it takes longer than what you would like or. And have you ever had a problem with taking too long from your first leg to the specialist you know. Like having to wait too long to go see a specialist in case you needed one and that created.
NO03: Yeah. Yeah.
R: And what does that waiting make you feel. Do you feel good. Do you feel anxious.
NO03: No. It makes me feel anxious. Again if it's something that I don't know. The outcome of what can be. You know it could. Would it be cancer. Would it be just an easy thing to solve with some medication or an operation or. So yeah sometimes it makes me anxious if it's too long to wait. Yeah. Yeah. But my my doctor again is very good in writing in the handbans. Yeah. You know about my medical history and trying to get you as quick as possible. Yeah.
R: So you are in a way very lucky that your first leg is very hands on and very proactive.
NO03: I am. I've always said that you know I would never change my first leg before he's a pensioner. Yeah. Because yeah. My daughter had the same doctor but she didn't have the same communication with him as me. So she changed. She felt that he didn't see her.
R: But yeah. Of course it has to be a connection. Otherwise you will feel that way.
NO03: Yeah. Because I felt that way myself with other doctors. So it has to be the chemistry you know. Yeah. It's a moment of luck. Yeah. There.
R: And in your perspective like how does the health care systems here in Norway affect your everyday life?
NO03: It makes me stay healthy in a way.
R: Yeah. And you feel safe that you can always go to it. Or do you feel insecure that you're not sure how you're going to be treated.
NO03: No. I've never been wrongly treated. So no I'm not afraid of that. It's been one or two occasion in the ER but that is a known thing that you know you're coming up there and they look at you like you've got five heads and why you're coming here with this kind of problem. And that's basically because my doctor has said to me that if the doctor's office is closed go to the ER. And it's in my medical history that that is what I'm supposed to do. So when they start looking at me like that at the ER I'm just saying check my medical history. Check my journal. Yeah. Check my journal. Have you looked in my journal before you.
R: So even though your relationship with your doctor is very good you feel that the ER at the hospital it's a place where you don't feel like they take you seriously or they hear your concerns.
NO03: Yeah.
R: And do you have any idea.

NO03: Until they look in my journal it's kind of they have way too many patients so they don't have even have time to look at your name you know. It's the nurse that shouts you in there and then a doctor is sitting there like looks like he hasn't slept for the last 48 hours or so. You know. So it's yeah again I think it boils down to short of staff. Yeah. You know. Medical medical shortage. Yeah.
R: So you think that's the main issue here. And that shortage in the hospital at least makes you feel unheard.
NO03: Yeah. Because they don't have the time. Yeah. To hear you. Yeah.
R: And you don't think that is because you're a woman you just think that is general.
NO03: That is general. Yeah. Yeah.
R: And is there anything else that you feel about the health care system here that you would like to share. Good experience bad experience or.
NO03: No. Mainly I only have good experience with the medical service. In 2017 when I had a cancer operation I I felt into like a depression and anxiety and so I was referred to the DPS as well. And even that didn't take long for my doctor to get me through the system to them. So yeah I feel I've been very been looked after. Yeah. You know. Yeah. Yeah. I do.
R: That's really good. Yeah. Yeah. Those were all my questions. Oh yeah.
NO03: That wasn't too bad.

INTERVIEW NORWEGIAN 04

R: Alright, so this is Norwegian 4 interview. So I'm just gonna ask you a little bit about the healthcare system here in Norway. And a little bit about your knowledge of the system. Do you know how to properly seek out medical help? What are the avenues that you have for it? And do you find that it's easy to do it?
NO04: I feel like it's slow here in Norway. You have to go first to an appointment. Then you go to the doctor and tell him what you want to talk about. And even if it's something that your doctor can do, you have to come back for another appointment. And if you want to a specialist or an MR or CT or whatever, you have to wait like 6 months to get it done. Or you have to pay to keep the line. I feel like the main problem is the amount of time that it takes to get things done.
R: Did you ever have any difficulties understanding how to properly use the medical services available?
NO04: No, I don't think so. But I always just use my doctor.
R: Do you know if there are any other services that are available that are not necessarily through your Fastlege? Like Gynekolog.

NO04: Yeah, Gynekolog or if you could go privately to a doctor or anything like that. I can go privately and if you're willing to pay, you can skip the system of the public and do mostly private. And then the time is also much better.
R: So you know what are the healthcare systems that are available?
NO04: I would say at least some of it. I don't know if I know every corner, but I know about it. It's a bit hard to know every corner as well.
R: So your main issue would be more like the time that it takes?
NO04: Yeah, from you finding a problem or something you're wondering about.
R: Do you get an answer about it or you get things checked out? How do you feel about always having to go through your FastLege for something? Sometimes you know you need something from a gynecologist. How do you feel about having to go through your FastLege before being able to get there?
NO04: I think it's annoying and unnecessary because I don't see why I can't just order an hour for myself. And without going to the private side, you always have to kind of get in handy. Yeah, yeah. And I feel it's unnecessary instead of just getting in the line. You kind of have to wait two or three weeks to go to your doctor. And then it's another, like I was to the gynecologist this fall. And I have waited for that in December. And I have waited for that since before June.
R: And how does that long waiting time make you feel? What do you feel about it?
NO04: I feel it's really annoying and unnecessary. And I would be scared if it felt like my problem was serious. If it was something I wanted to have done just now.
R: So it makes you a little bit anxious?
NO04: Yeah, I don't like it. If you feel sick, for example, I hope it would go much faster. And then you have to wait like half a year to get something checked out. It feels scary.
R: How long after you present symptoms do you usually seek out medical care?
NO04: I would say it depends on the problem. If I just have a cold or a fever, I would wait at least a week, I think. Before I even contacted a doctor. And if I had an emergency, I would go straight away. And I also feel like my doctor got changed. Because the last one quit. Retired or something. So I got a male doctor instead of a female. So if I had fever issues, I would probably hold back a bit to see if I actually needed to go to the doctor.
R: So it would make you not seek out?
NO04: Yeah, because I wouldn't be comfortable about it.
R: Do you find it easy to seek out medical care?
NO04: If it's anything not like instinctively female, I feel it's easy.
R: Is there any external factor that prevents you from seeking medical care when you're in need of it?
NO04: Sorry, once more.
R: External factors like you're afraid of affecting your work or money-wise you think you have to pay too much.
NO04: No, for my sake I would just go to the doctor. The workplace is fine and our economy is good. So if we had to pay, we would make it anyway.
R: You just mentioned that now you have a male fast leg. Do you trust him?
NO04: Yes, I do.
R: Do you feel like he hears your concerns? That he takes you seriously?
NO04: Yeah, I have been to many doctors.
R: Multiply? Multiple? Multiple.
NO04: Yeah, multiple doctors here. And some have just been very closed. But he kind of tries to go into my place and see the issues from my side of the spectrum. So I feel he wishes me well. So he's there for me and not just to do the work. So that's good. I like that about him.

R: Do you feel comfortable sharing any type of information that could affect your health with him? You mentioned a little bit about...
NO04: Just the particular female parts. I would rather go to a female gynecologist. Have him examine you. But that's kind of a preference. But except for that, it's better to get checked out than to hide something and then find out you checked out too late.
R: Is there anything that you would like to change regarding your relationship with your fast leg?
NO04: That it's more available. Because there's always waiting time. When I contacted him in June, I got an hour in the end of August. Because it wasn't serious or it wasn't an emergency.
R: So you just feel like unless you have something seriously, it just takes too much time.
NO04: Yeah, it takes a lot of time. It's more of like preventive medicine. If you're serious, they'll take you faster. But if it's not serious... But still, they told me, if it's an emergency... Because we have the same daughter from both Matilda and Maja. So I called with Maja. She had a rash and stuff. And then they just said, you have to call at 8.30 to get an appointment. Because everything is full. It's kind of sad that you can't just call. And within two weeks you can get to the doctor. You have to wait like a month. Because you can have something that's...
R: You might not know it's serious, but it could be serious.
NO04: Yeah, it could be serious. And it also could be something that is easily solved. But instead of just getting it solved within a week or two... You will have the problem stuck for two months. Because you have to wait for a consultation. And I feel that's bad. And it's unnecessary.
R: Does that time that takes to seek out a doctor... Does that make you want to seek out doctors less? Or does it impact you at all? Does it make you wait longer to seek out a doctor... If you have symptoms for things, for instance?
NO04: I try not to. But it doesn't get me to seek out medical help sooner either. Because I still want to be sure before I book my appointment. Because I know it's so busy.
R: So you don't want to go there and be like... Oh yeah, but I have a little scratch. Can you check it out? Because you know that they have so much to do. And instead of... So you feel like you shouldn't bother them with things that are little.
NO04: You should only go if you feel like it's something more serious.
R: Do you feel like your fast legged and the receptionists and everybody... Are forthcoming with information for you?
NO04: With the information they got, I think they're forthcoming. But I haven't asked for so much information from them. And when it comes to booking... Getting in contact, that's always hard. They're always restricted on giving contact information. Or somewhere to post or send. That's always hard. That's kind of what you're asking. Oh shit, I forgot the question.
R: And do you feel like you have... When you go to the fast legge and you take an exam or something like that... Do you feel like you have enough feedback from what is happening? Do you feel like information about your health is available to you?
NO04: I would like to be able to see his notes. And I know you can log in to like HelseNorge and stuff. But everything is always closed. And the same goes for my children. That I would like to... Like, okay, what did you send? And how did you write it? What is your...
R: You want to have more transparency regarding your medical information for you.
NO04: Yeah, because I feel like it's about me. So I should know what is going on. And when things get sent, when they get a response... I mean, it's not that you have to read everything. But to know that someone has seen the mails or... When you get an appointment, that you know that you actually... A human doctor actually has touched it, kind of. Yeah. Because I feel... You get to come to your doctor and he says, okay, I'll send it to the next one. And then maybe you get a letter in the post. Four, five, six weeks later. And then again it's a half a year waiting before you get your appointment.

R: So what do you think about this lack of transparency? How does that, you know...
NO04; I'm always going out with that people are... At their best intention. So it doesn't bother me that much. So I don't think people want me ill. But still I'm kind of curious. And you just want to see if there's any progress. And that I lack.
R: Do you believe that the medical treatment you receive here in Kristiansand... Is adequate to your needs?
NO04: So far it's been. But you always hear stories. So I haven't been seriously ill. So I can't really comment about how it would have been if I was. If they got it sooner. Did I check it? Did I send the right tests? You hear both things. Of course it's scary to hear that someone almost died because the doctor did a mistake. But that's also something that's not necessarily restricted to here. That's something that happens unfortunately everywhere. Because doctors are also people. They also make mistakes. So for my sake and the issues I've been having... It's not been anything big and it's been kind of an easy fix. So I feel like they've made it. They've made it good again.
R: In your perspective, how does the healthcare services affect your everyday life? Like with the time frame? With everything. Does it make you maybe not want to do something for fear that you might need a doctor and you won't be available?
NO04: No, I try not to let it affect my life. Because I know if you get an emergency sick, then you will call an ambulance and you will be rolled into the hospital. So you feel very comfortable with the medical care here.
R: You feel like you can trust it to have your best intentions.
NO04: I'm also from out of town. So I've been living in a little town where you don't have a hospital. You don't have the big things close. So I feel much safer knowing that if I get an emergency sick or something happens, it's 10 minutes, 5 minutes, 20 minutes. Instead of an hour or two or three. So in that way it's safer to live close to or in a big town. Or in the city or whatever you want to call it.
R: That was about it.

INTERVIEW NORWEGIAN 05
R: Alright, so this is interview with Norwegian Five. So we're just going to talk a little bit about your knowledge of the healthcare system here in Norway. And do you know how to properly seek out medical help here when you need? And have you ever had any difficulties understanding how to properly use the medical services available?
NO05: No.
R: And do you think it's very easy to use it? Do you think it's...
NO05: I think it depends... I think it depends on what's wrong with you. It's easy to seek out, but it's harder to actually get the help that you need. So, for instance, right now... Oh, I'm sorry.
R: No, no, it's fine.
NO05: It's just... Right now, where the economy is what it is, I know that it's so hard being, let's say, a drug addict. Or a person who needs mental health, because there are so many places that are shutting down. Some of the private sectors as well are shutting down. So there's such

a waiting list, especially young people are really good at going to seek help. It's harder for the older generation, but...
R: Yeah. So you find it easy to navigate the information that's available? It's just hard to get the actual help.
NO05: Yes. Mostly because of long waiting times and things like that. And especially as well, when you're a woman, I don't think I know anywhere, and that does not include... That, of course, includes Norway as well, where female health has been really on the agenda. I know that it's changing in Norway right now, but it's too little too late. But yeah, there's a lot of progress as well.
R: And do you know which healthcare systems are available here for you, and how to reach them?
NO05: Do you think the public or the private?
R: Both.
NO05: Both? Yeah, everything.
R: Do you understand how to navigate everything?
NO05: Yeah. The only thing that can be hard, or it's not hard, but it depends what kind of doctor you do have. For example, I go to a private gynecologist, and if I haven't been there for a year, then I need to go to my doctor's first, because he needs to send me off.
R: So you don't use a gynecologist through the public offering?
NO05: I don't know. It was my last doctor who sent me to this doctor, because he has a really good reputation. And I just stuck with him, because he's an expert in his field. And because I have certain diagnoses, that I just feel safer being with someone I've been going to before. That already has your history. Yeah. And as well, he has a collaboration with the public system. So that is why I could transfer there. It's the same with mental health. If you go to a private one, but you were sent from your doctors, that usually means that they don't send you to a private one where you have to pay loads of money. They send you to a private one, if they have a collaboration with the public system. Because then it goes on your free card.
R: So you were referred to the private, and you can go through your public free card as well. How did you combine that information, that you can go to the private and it was very fast like it?
NO05: I don't know. Others have done it as well. It's hard to understand how the system works. I have full appreciation of that. I do understand it. Luckily, my first leg and the one before as well has been really good.
R: So you think they helped you understand the system?
NO05: I just think that they understand the system. So in referring me to different specialists or whatever, I kind of understand it as well. Because you know where you're going. So yeah, that's really good as well.
R: Do you trust your fast leg?
NO05: Yeah.
R: You have complete trust in him?
NO05: Absolutely.
R: Do you feel like he hears you?
NO05: Yeah.
R: He hears your concerns and he takes you seriously?
NO05: Yes. The one thing that I'm... I believe maybe this is my opinion, but I think a lot of doctors are really good at prescribing drugs. Because you should not be in pain, so here are some drugs. I usually never take pain medicine and my doctor knows this, but before he knew that as well, he never recommends me to do any medicine of any kind before we actually know what the problem is. But I was in Legevakt during Christmas and they just prescribed me pills

that I couldn't drive with and some other drugs like cortisone without even knowing what the problem was, which I don't like. So yeah, I do trust my past leg.
R: So you trust your past leg, but you feel like Legevakt...
NO05: Yeah, I feel like of course there are different doctors. Yeah, and I'm lucky with mine.
R: Do you feel comfortable sharing any type of information that can affect your health and treatment with him? And is there anything you would like to change regarding your relationship with him? He is a guy, right?
NO05: Yeah, he's a man. All my doctors are men. For some reason, I don't know why. But yeah, no, I don't think so. The only thing is that, as we've seen in newspapers and stuff, Fastlege has a lot to do. Like long hours, a lot of people going on their list. And maybe, hopefully, that will change, that they will have more time for their clients, maybe more Fastleges. I don't know how they're going to work it out. That's not my field. But I feel like that is the only thing. Because if I don't have anything that needs to be sorted right now, there could be a two-week, three-week waiting list. To get an appointment with your doctors. And if not, you have to call at, when they open, to get one of those emergency appointments. Which is just stupid. It doesn't really bother me that much. But for people who have general stuff, three weeks waiting time can be quite tough when you're at work. If you're a mom or a dad.
R: So for you, the only problem that you have with your Fast Lego is the waiting time.
NO05: Yeah, it's a system.
R: It's not the Fastlege itself, it's more the system.
NO05: Yeah, exactly.
R: And have you ever changed your Fast Lego?
NO05: I did have to change, because he started working in the hospital. So it wasn't a choice. It wasn't a choice, no. So if that, I would have stayed with him. But then this guy came in and took over his job.
R: And you get a little bit skeptical, because he's going to be a Fastlege.
NO05: But no, I love him. He's really good.
R: Do you feel that the medical personnel here, your Fastlege, the people working there, do you feel like they're forthcoming with information and it gives you enough information to make good informed decisions about your health?
NO05: I believe my Fastlege does that. He's open about, this is not my field, I'm going to send you to a specialist. Which I know that if he makes a diagnosis or if there's something wrong and he knows what it is, that makes me more, kind of, yeah, I know I can trust him when he actually does give me an answer. But he's really open, like, this is not my field, I have to send you to someone who knows what they're doing. But I think, you know, doctors are people as well, and people are different. So some doctors don't see patients, they see what they now call brugere. Yeah, users, consumers. Which I absolutely hate that term. I don't think that should be anything used. Patients are patients. Patients are meant to be cared for. But brugere is more, you know... Impersonal. Yes. And of course doctors are the same. Some people are just like, yeah, I know what's wrong with you here or something, or do this and this, but you don't quite understand it. I think a lot of fast Lego as well has very little time for their patients. So they give you a pamphlet or go and search online instead of having the actual conversation with the patient. That's at least my understanding with talking to other people as well.
R: So you feel insecure because you know that what's online always ends up with you having AIDS or cancer. You're always dying.
NO05: So of course you can search up a diagnosis and then read about it, but what if you have questions afterwards? Who are you going to ask? Not the internet, because then you have AIDS or cancer. So yeah, I think there's a lot missing within time and actually seeing the person in front of you that's in a vulnerable position. But I think that's more a systemic fault than it is the doctor's fault. But of course doctors are different. You can absolutely have a doctor that you

don't trust, that you don't like, because their personality type and the way they speak to you is different than what you imagine or need.
R: Do you think you receive enough feedback about your health here?
NO05: Yeah.
R: What about transparency about your medical information? Are you able to access that? Is it easy for you to access that?
NO05: Well, I think because it's a public system, so you do have the apps, you have the patient cloud, you have health.org app, so you can easily access if you have any new appointments or if you have any feedback on your tests or whatever. You will get notifications and you will get the answers and then the doctor writes to you, so you get the information quite fast. But the apps suck and you get it in so many different places. So for me, I'm not a genius when it comes to technology, so I find it quite hard. I can't believe how it is for the older generation. It's just how they structure the system at the moment. But yeah, it is easy access. You just have to get some time to get to know the apps.
R: How long after you present symptoms do you usually seek out medical care?
NO05: A long time. A long time.
R: Why do you think that is?
NO05: I think it's just because of work and usually I feel like it's nothing. So if I have a sniffle, I'm not going to go to the doctors. One, I know that it's hard to get an appointment, so I usually don't go if I don't need to or feel the need to. And as well, because of my work, I usually just power through and go to work.
R: So work is an external factor that stops you from seeking medical care.
NO05: Absolutely. Yeah, yeah. And I think for me as well, why do I need to go to the doctors if I have the sniffles? Why do I need to go to the doctors if I think it's the flu or influenza? I don't see the need for it because usually you get well after a week maximum. The only way of calling my doctor is if I need to have sick leave or sick night. And they usually want you to come down so they can check you and make sure you're alright. That's the only time.
R: Yeah. And do you find it easy to seek out medical care here when you need it?
NO05: Well, I call when I need it. Yeah. I don't, I don't understand.
R: Yeah. Yeah. And like you mentioned a little bit about the waiting time. Yeah. Like does that hinder you from seeking out medical care at all?
NO05: Maybe a little. Yeah. So I usually wait until it's really bad. Yeah.
R: Because then you can get one of those.
NO05: Then you can get faster.
R: Yeah. Yeah. And then you can get better.
NO05: Yeah. I usually think that it's going to blow over. Yeah. Yeah. So if you have to wait two weeks to go to the normal doctors, you know, you're usually not dying. So I usually just put it off because I expect to be fine within two weeks. So why is the point of going to the doctors then? Then you're just taking up his time, your time, the work's time. Like I don't see the point.
R: So you just kind of wait to see if you get better. And then if you become something more acute, then you seek out help.
NO05: Yeah. Because then I know it's something wrong. Yeah. Yeah, usually. If you have a sore throat, then I don't go to the doctors. But if it's something worse, like if you need antibiotics, then you kind of have to.
R: So in a way, like you and you feel like the system here is not proactive. It's more like you wait until it's a little bit worse.
NO05: Yeah. Yeah.
R: So you're more reactive to the level of symptoms that you have.

NO05: Yes. And I don't, that does not have to do anything with the system. Yeah. It's just, that is just me personally. I don't like taking up someone's time if it's not worth it. Or, yeah.
R: So those are some external factors that prevents you from seeking medical care, like work and taking someone's time. But then. Is there anything else?
NO05: No. No. No, not really. Yeah. It's just like work as well. It doesn't prevent me from going. Yeah. It's just, I think it's just my personality. If I don't have to, then I don't do it.
R: So it just discourages you a little bit, but it's not like a barrier.
NO05: Yeah, no, no, no. If you feel like you need it. If I need to, I need to. Yeah. And if I want to, I want to.
R: And do you believe that the medical treatment that you receive here is adequate to your needs?
NO05: For me, yes. Yes. Because I've been lucky with my health. But for others, no. The system is changing. We all know it. And we're going towards a more privatized way of looking at the health sector, which I do not fancy and I do not like. Which also means that the queues are getting longer. And if you're rich, then you could go or have enough money, especially in the economy we have now. We see that a lot of people from the middle class are moving downwards from above as well. But, you know, the rich are usually so rich that a few million doesn't matter. I see people with a diagnosis that that's for life. That I believe you could go to another country to get some sort of treatment for that is not accessible in Norway.
R: And how does that make you feel, knowing that those type of treatments are not as accessible here anymore?
NO05: I don't think it's not because it's not anymore. It's just not taken in because it costs too much money. And because it's the government who pays for the health system, or the public health system. They don't want to, or they... They don't kind of... Not want to, but they don't... I think Norway is a country that is like... They want to maybe wait until they know for sure that this treatment is right for those... So they take a little bit longer to take decisions. So it works in 50 other countries, then maybe we can introduce it here. So you're not in the forefront of things. You're more like... Yeah, and that's something that maybe annoys me. With our country, with our technology, we should be focusing more on health. And not, for example, like America, privatize it and then the drug companies owns the world. I know in Norway as well, when you go to the pharmacy and you've been prescribed a drug of some kind, and then the people in the pharmacy say, but we have this, this is the same, but it's cheaper because it's from another producer. Then, of course, you take the cheapest because it's the same thing. Luckily, we have the pharmacy that usually I've never had anyone who hasn't given me the option of taking the cheaper option, which is the same thing. But as well, you know, in Norway, they have to pay the price that they have to pay for the drugs. But when it comes to treatments and stuff like that, we could be more productive. I think that is one of the things that we're kind of lacking. We should be more focused on it. Yeah, a bit more hands-on with things like that. We could get people, like more people, instead of focusing maybe in some areas of Norway, we could get focus on more on getting scientists, microbiologists, right? You could invest more in the medical personnel in the country. Yeah, and the science department and, you know, trying to be more proactive.
R: Yeah. And in your perspective, how does the healthcare systems here affect your everyday life?
NO05: Very little. Yeah.
R: You don't think it has a big impact on your life?
NO05: Well, of course, I have, me personally, have some diagnoses that do affect my everyday life. That is my health. It's not the healthcare system. It's just some diagnosis I heard today.
R: And you have enough support for those diagnoses, you feel like?
NO05: Yeah. Yeah,

R: so it makes you feel safe knowing that you have that here.
NO05: Absolutely. I do have an excellent example. I went to the doctors in June, July, because for several years I have pain in my legs. And I went to the doctors and he told me that he needed to send me to a specialist because my dad has a diagnosis, like a nerve thing, and they think that I had it as well. And I got a letter from the hospital, because you have to go to the orthopedics department. And then they said I would get an appointment within the 7th of January. Today is the 16th.
R: You still haven't gotten it?
NO05: No. So what I did, I went to a private sector. I went to a place called Blashford. They have an ortho there, and then a physiotherapist and stuff. And then I went there. I had one appointment with him. Everything within two weeks. They had a diagnosis, they knew what needed to be done, everything. And then they said you don't need to pay. We have to send a letter to NAV to apply for... It's like you get money to buy shoes and stuff like that. Yeah, yeah. That are formed to my feet. And then I had to wait six weeks for the letter from NAV. So then it's a public system again. But then they changed it to eight weeks. So for eight weeks, everything happened within two weeks. Yeah. The appointments, everything in the private sector. Then the public sector, I had to wait eight weeks. And then it was 12 weeks. And then I got a yes. And then I just called them and said hi, I got a yes. They're like, yeah, come in tomorrow. And I got in. And then everything was done in a day. Yeah. So it takes a while for things to get moving, but once they get rolling... That was the private sector. Yeah. And I went there by myself. But if it's been the public system, I would still be waiting to get my shoes. I would still be waiting to get the soles. Because nothing has been happening. But they as well, once I got the yes from NAV, I had to pay the small private fee. Nothing more.
R: Yeah. So how do you feel about that, that you had to go through the private one instead of the public one to actually get something?
NO05: Yeah, it's... I just feel like for people who don't have the ability or the money to do it, because if I got a no from NAV, I had to pay everything for myself, right?
R: Yeah. So you never know. Yeah. And then... So it sucks, kind of. Because the system should be better.
NO05: I'm still waiting for the appointment at the hospital. Because now it's... Because I've been walking with the shoes and everything, then we have to talk about surgery. So... So I have to talk about surgery, for example. But if I hadn't gone to the private sector, if I hadn't known where to go, then I would still be waiting for my first appointment. For anything. Yeah. And you're in the letter as well. Within six months, I can demand an appointment. But when I call them, I know they're swamped. It has been icy. They're doing back-to-back surgeries, people breaking their hip. So for that, I do know that it's more acute. And right now I'm not in so much pain. So for me, it's fine. But for people who are in more pain and having issues, they have to wait six months. Yeah. So the system is broken in many ways. We're lucky to have a system that we do. But we absolutely strive to be better.
R: Yeah. And have you ever felt any type of discrimination of not being taken seriously, not being heard, because you're a woman? Have you ever felt that a doctor here, your first lady or a lady doctor, someone has disregarded you because you're a woman?
NO05: No.
R: No? Never. You've never had a problem with that?
NO05: No. What I am afraid of is that we don't focus on women's health enough. So, what is it, every two years you get a letter in the mailbox reminding you to go and take the... Pap smear. Yeah. Which is good. But women's health is much more than, you know, that. I know they're focusing more on that right now. I know I trust my doctor, my gynecologist, in that way. So I have no issues whatsoever. I feel like I'm getting the help that I need, if I need anything. But for many other people, it's not the same way. And there's so much happening down there, which

is a science just on its own. And I feel like, of what I've experienced, not by myself, but with others, that you get... It's like, oh shit, you have to walk like that in like three months and then we can take care of you then. Yeah. With certain things that it's not only uncomfortable, but it's painful as well. Yeah. And that is examples that I hear often. Yeah. I'm lucky, never been in that situation. But I hope that the day I... If I get into a situation like that, I don't have to go three months with pain. Yeah. Or something falling out, or...
R: How does it make you feel, knowing that you might have to wait three months if something like that happens?
NO05: Yeah, I'm not waiting three months.
R: Yeah, so you'll find other avenues that don't rely on the system...
NO05: No, I trust my doctors. ...to push it through. Yeah. Yeah. And that is why I'm lucky. And I believe that I have doctors that will do the necessary steps for me. I don't think everyone has it that way. Yeah. Yeah. I trust my doctors completely. That's it.
R: Is there anything else you would like to comment or anything?
NO05: No. Yeah? I think that... That summons up your... Yeah, I think... You know, I trust the health system. Despite its faults, it's so big. It is a good system. It's better than, what, America? That's a long one. A lot of other places. Yeah, it is. But, yeah, we do have one of the best health systems in the world. Yeah. We shouldn't stop, right? We should only pursue to be better. So, yeah, no. And women's health as well. I have the... I'm in the understanding that women's health are being more focused on, have more research on it. People are more aware of it as well. I don't think that it's good enough yet. Yeah. It's the same with vaccines as well. They do it in a way that... For example, the COVID vaccine is made in the way that we always make vaccines, which is with the biology of men, not women. Yeah. Yeah. So we saw that so many people had, or so many women had issues after taking the COVID vaccine because we're women. We're both different. That is just biology. Biologically correct, which means that it can affect us differently. We're 50% of the people in the world. So we should be counted and we should be, you know, it should be tested and made for both. Not, whoops, that happened. That affected, let's say, 10% of the women in one country. So yeah, there's loads to be done. But yeah, no, I trust my system. Yeah. Yeah.
R: That's really good. Thank you very much.
NO05: No, that's all right.

INTERVIEW NORWEGIAN 06
R: This is an interview with Norwegian Six. So we're just going to start talking a little bit about your knowledge of the healthcare system here in Norway. Yeah. And do you know how to properly seek out medical care here?

NO06: Yes. Yeah, I would say so. Yeah.
R: And have you ever had any difficulties understanding how to properly use the medical services available?
NO06: I struggled a bit with health in Norway. Yeah. I used to have a legecenter in Vågsbygd, and you couldn't apply, like you couldn't order a time. Yeah. My English. Yeah. Sorry. I couldn't like make an appointment on the online apparently, but when I called them, they said make an appointment online. So it was like an infinite loop until I finally managed to call them a couple of times. And then that happened. But now I don't go to Vågsbygd anymore. So it was more like a system failure than anything else.
R: And do you know which healthcare systems or services are available and how to reach the different ones?
NO06: Yeah, I think so. Yeah. I mean, what do you mean? Like Legevakten?
R: Yeah, Legevakt, hospital, Helsestation if you need it.
NO06: Yeah, I don't know where the Legevakt is actually. Isn't it near the hospital as well?
R: Yeah, it is near the hospital.
NO06: Okay, yeah. So we have that one. And I know where my doctor is. Yeah. And I know where the hospital is.
R: So. But if you need something specialized or something like that, do you know how to get that?
NO06: What do you mean specialized?
R: A specialist or something like that. Do you know how to?
NO06: No, I would just if I were in that position, I would just go to my doctor first. Yeah. And then take it from there and make them figure it out for me.
R: And do you find it easy to seek out medical care here?
NO06: Yeah, I would say so. You get an appointment relatively fast. I made an appointment one month ago for my doctor.
R: So you think one month is relatively fast?
NO06: If it's not urgent, I would say that's okay. I mean, I had experiences where I needed urgent care and I got it the day after. So that was also, but that was in a different city when I lived in Stavanger. So, or I got it the same day. Yeah. So that was different. I can't remember if I did need urgent care here at the medical office yet. Yeah. To be honest. Yeah.
R: But you haven't had any problems or anything like that to reach out to medical services and you think that one month waiting time for something mild is okay?
NO06: Honestly, that was fine. Because that was just like a normal checkup. It wasn't something that was bothering me or something like this. Before, I can't remember, but before I think it's been like maybe a week or something. This was just me being a bit ahead of schedule because that was last month. And I made the appointment for January. But I don't know. Usually it's been maybe shorter. Yeah. So I think the best amount of time would be maybe maximum one week. Yeah, I think so.
R: That would be preferable for you.
NO06: Yeah. Because I mean, I made the appointment in like December or November for January because I was like, yeah, I need a doctor's appointment because I lived in a niche for six months just to check up if everything is as it is. And that was just me being in advance, I think.
R: Yeah, you were just being a bit proactive with your...
NO06: Yeah. Yeah.
R: And how long after you present symptoms do you usually seek out medical help?
NO06: I mean, maybe if the symptoms are there for a week straight, I would say I would check it out.
R: And why do you have to have symptoms for a week before checking it out?

NO06: It really depends though on the symptoms because there has been stuff I've been working with for a week, stuff I've been having for like a month to see if it... It depends on what I have, right? Yeah. And I don't like doctors. I don't like going to doctors and going to seeking out. I know that's a very Norwegian thing. I don't want to make a bother or something.
R: You just don't want to bother them if you don't think it's serious.
NO06: Yeah, and it's so embarrassing going to the medical office like, hi, I'm so bad and ill and blah, blah, blah. And they're like, no, you're fine, right? Yeah. It feels like you're kind of people combat.
R: So the fact that if they think that you don't have anything serious and they kind of just dismiss you, it makes you feel bad. Yeah. For imposing on them.
NO06: Yeah, exactly. It's embarrassing and you feel dumb, right? And everything. I feel like I waste their time because their time is...
R: Even though you had a valid medical concern probably, but if it wasn't serious enough, they make you feel like you're imposing on them.
NO06: Yeah, maybe it's both. They make me feel that, but also I make it myself because I know they're so busy. The nurses and the doctors and everyone is so overworked. So I know that they have so much work to do already. And then I'm just going to come here with like, hi, my head hurts stuff. Or it's not like that, but you know what I mean?
R: Yeah, but if you're going there, it's because you're presenting something that you don't know what it is. So you could be afraid.
NO06: Yeah, that's true.
R: Do you think they could be maybe a little bit more open to hearing you and trying to understand the reasons why you're going there?
NO06: Yes. I mean, yeah, from what I experienced, sometimes I feel like I have to kind of fight for my cause. Because sometimes I have been in the right. I have been needing medical care and I did not get it in the beginning. And then they finally said, okay, you're sick, we'll manage. And sometimes when I know what I have, kind of because I experienced it before. For example, I just go to the doctors and say, I have this, I need this. I am 100% sure we can do the tests. Because then I'm a bit more like firm on it. And then they say, yeah, okay. Because I've realized that if I go like, I think there's something wrong with this and this, they just reject it.
R: So if you're more proactive and more informed about what's going on, they tend to take you more seriously.
NO06: Yeah, that's true. And if I'm more stern about it, but the problem is, the problem occurs when I don't know what's the problem. So if I have pain or if I have stuff that's not familiar to me, I don't know about it. It's more than I don't know what to do. And I come here and talk about it to the doctors and they're like, yeah, you're fine. Because I undersell it maybe or yeah. Yeah, but they don't investigate and then don't... It depends. Yeah. I don't know. It hasn't... I don't go to the doctors that often, to be honest.
R: But how does that make you feel that like they only take you seriously and move forward with your treatment if you already know what you have? And when you go there and you're a bit unsure, you're just presenting systems, they just kind of let it go.
NO06: I mean, I get it, though, because as I said, they probably get a lot of people that do the same thing without having any problems. And that only has happened a couple of times where this is getting rejected. Usually I come in and it's like I go to the doctor. That's why I wait so long as well. I go to the doctor when something is really wrong. It's like I know that I will probably get medical care because I do not like going to the doctors at all. So, but yeah, it's it's it feels kind of embarrassing when it's when you go saying symptoms and they're like, no, you're fine.
R: Yeah. It's just not a good feeling at all.
NO06: No, no, no, not at all.

R: And does that discourage you from seeking out medical care at all?
NO06: Yeah, definitely. I mean, that's the reason why I wait so long to know for sure something is wrong, because I don't want that rejection. I want to be able to like come out with I don't know. It's not like I need to come out with medication. It's more like I need to come out with recognition. Yeah. And actually know that I was right. There is something wrong and it should not be like this. Feel validated in a sense. Right. And I would not get it if I don't like have problems for maybe a week and I can tell about them for a week or something. Yeah, I think I feel like.
R: Yeah. And we're going to talk a little bit about your relationship with your fast leg. And is your fast leg a man or a woman or you're not comfortable sharing a woman?
NO06: Yeah.
R: And have you ever changed fast like it?
NO06: Yes.
R: Why? What was the reason that made you change fast like it?
NO06: So I moved here in 2020 and I chose the first available one. And that was in Voxpict. OK. And she was on sick leave when I chose her, which I didn't know when I chose her. So I got a temp for her and I went to her for the first time. I was like, yeah, OK. And then maybe six months later, I wanted to see my fast leg again. And she was still on sick leave. And I got another temp. And that was a man and he helped me out and everything. I did get good help. Yeah. But I never met my actual fast leg. So after a year, I put on put myself on waiting list on this close by UIA. Yeah. Because I wanted to do something closer as well, because Voxpict is far away. And I saw that there was one woman, the one I have now. She has two in line. And I was OK, fine. I'll go back behind her. And I got her. I think I put myself in her queue maybe a year after a year before I got her. So I got her this fall. Yeah. And then now in January, that was the first time I met her. OK.
R: So. So do you trust her? Like you haven't had a long time.
NO06: No, I cannot say I trust her at all. I haven't I haven't really gotten to know her. And we've only met once for briefly for 15 minutes. I mean, she did. She did go to some extent to take some of my needs into care. But it was a bit of a mix there, to be honest.
R:Yeah. So do you feel like she hears you?
NO06: Maybe not that much. Not that much. I think I will have to be a bit more persistent. But again, I understand what why she did not hear me and my concerns and everything because of previous problems. But I don't know, it's it's I did not get what I expected after that meeting, to be honest.
R: Yeah. So you felt a little. Yeah. Brushed away.
NO06: Yeah. Yeah. And what do you think about that, that your own fest like it kind of brushes you away?
R: I mean, it's kind of shitty, you know, because you're supposed to listen to your patients. You're supposed to. We're adult people going to this getting seeking medical care. And in Norwegian culture, it's very common to not seek medical care unless something is actually wrong with you. I think from my perspective and when actually a grown woman comes and says something is wrong, that should be enough, shouldn't it? But it's not enough. So I don't know.
NO06: So you have to be much, much bigger advocate for yourself and much more vocal in order to get any type of care.
R: Definitely. Definitely. You have to come with arguments and come with. And what the problem was, I did not I get instant rejection at first and then I kind of persuade a bit more. Yeah. It was a bit more persistent and then still rejection, but some other roots. And then lastly, I was like continuously argumenting my case, pleading my case. And she was it seemed like she loosened up and she's still like with her foot halfway on the way back because.

R: So just a lot of resistance.
NO06: A lot of resistance. Listen to you.
R: Yeah. And what do you think about that?
NO06: I don't think that's her fault, in my opinion. I understand. I think that's because you see that in all the fast leg is. I don't think that's like the singular person's fault. I think that's the system's fault, because right now they have a thousand thousand people each for one person. And yes, they do make a lot of money, but money can only solve something. They cannot buy time. Right. And if you don't have time to treat your patients, then there's no point. And the fact that you only get like 20 minutes to treat each person. Actually, what's the problem is it's it's impossible. Right. People can't even tell you what's wrong in 20 minutes. Yeah, exactly. So I don't know. I think the system should be different because right now it's it's it's absurd how much they work.
R: Yeah. And yeah. And do you feel comfortable sharing any type of information that can affect your health or treatment with her with your fast leg?
NO06: Yeah, I'm pretty open about that stuff. Honestly, I don't really care. Yeah. What's wrong is wrong. What's right is right.
R: And is there anything you would like to change regarding your relationship with your fast leg?
NO06: I would like to what to change. Oh, I don't know. The fact that I have a fast leg that's very close, that's fine. Yeah. As I said, I don't really go that much. I just need one to provide if I think averagely I go every second year. Yeah. So I just need for those tiny things in every second second year. So, yeah, what what she does then, that's fine. And then I have other services for other needs and everything. So, yeah.
R: And do you feel like medical personnel as a general here and your fast leg as well is forthcoming and provides you enough information to make informed decisions about your health?
NO06: That's really difficult to answer, I think, because I haven't really gotten any experience from like medical professions here in Kristiansand. In my opinion, I've been a bit of with SIA Hälse. Yeah. And yeah, this and Vågspygd and there was just I would say no, maybe because I don't think I have gotten anything. Yeah.
R: If you if you like, do they give you when you say, oh, I'm presenting symptoms and they give you like what it could be and what are the options of treatments and like give you information so that you can make good informed decisions.
NO06: Usually when I come with problems, I already have the solution, you know, so that's why I'm waiting all the time. I have this. I'm sorry to have Googled the symptoms because I always do that.
R: Yeah, everyone does that.
NO06: And I always say like, yeah, sorry, I Google my symptoms and I talk to my aunt, which is also a doctor. And that's like my second step in the way. And and we discussed and usually I'm pretty sure I have this. Can we check for that? And if not, we take it from there. And 90 percent of the time is that one.
R: So then we just get you already very well informed by yourself.
NO06: Yeah. Yeah.
R: And do you think you receive enough feedback about your health from them?
NO06: About like my general health.
R: Yeah.
NO06: No, no. I mean, I haven't gotten like any anything directly that I should fix this or do this or anything. It's more in terms of like doing the medication. I usually get that from a boutique. Yeah. Like they give the this is how you do it.
R: And the same with the doctor itself doesn't do any follow ups or anything like that with you.

NO06: No, I don't think they did, because I went to physio for my knee the other like last year and they that was the physio that called me and the same with the vaccine. Yeah, no, it was usually it's other services. Other services. Yeah.
R: So the doctor itself never follows up to see if the treatment actually worked or.
NO06: Oh, no, no, no. They just assume that since you're not back, everything is fine. Yeah. Yeah. That has never happened to me. Not even Christian. Norway. Yeah.
R: And do you think that you have enough transparency about your medical information? Can you access it easily? Exam results, doctor's notes and everything like that?
NO06: Yeah. On the Internet. Yeah, definitely. The only thing is I'm curious about my blood type because I cannot access that easily. I have to go to the blood bank and ask, like, what is this? That's the only thing I think is weird. Why do we not have this? Because it's kind of important. Imagine an emergency and you need to donate. You don't know your blood type. And it's quite important. Yeah, it is. And you cannot check that online. And it's such a simple information as well. It really is. And the funny thing is, this is a regression. Sorry. I donated blood in Stavanger. And then they said I was all negative. I asked and I wrote it down on my phone. And now I donate. And Chris Elsaner is like, yeah, you're all positive. Fuck. And I don't understand what has happened. Did I change? No, it's not possible to change. It's not possible, right? I only heard about people being it's possible to change if you're pregnant. The baby has, but I've never been pregnant. So that's not possible. So it's probably a miscommunication somewhere in the medical field.
R: Yes. And do you believe that the medical treatment you receive here is adequate to your needs?
NO06: Yes, to a certain extent. I mean, I'm still going under a couple of things right now, which I am not very happy about. But we'll see how that turns out. I'll be a bit more persistent. Yeah. But usually it has they have met my needs and done what I when you're persistent, when I'm persistent, and when I know what I need.
R: Yeah. And, uh, in a perspective, like, how does healthcare services here affect your everyday life?
NO06: The health in general, general, not really that much, to be honest. I mean, the only thing is, it's for the second, like for my grandma, how the healthcare system affects her, because I treat I spent a lot of time with her. Yeah. And help her a lot. But she hasn't gotten a lot of help, in my opinion, as she should, because the healthcare I feel like it's not a good idea. I mean, she has gotten a lot of help, but she could get a lot more. Yeah. But apparently, she's too healthy for a 94 year old. And there's other people in line and blah, blah, blah, they're overworked and stuff like this. So yeah, I think that's what affects my daily day life.
R: How does that make you feel that you, you think that she should be getting more like, does it make you scared for your future?
NO06: Like, I haven't really thought about it. I just get angry. And I think it's unfair. Yeah. Because I think I don't think it's terrifying for my future. I think it's more scary for my parents' future. Yeah. Because they're gonna be excuse my language, but they're gonna be fucked when they're senior citizens, because we have no us, our generation is not nearly as much take care of my parents generation, like the baby boomers, right? That's a massive amount of people. So that's what I'm most, most scared about, like, but I did not choose working in the health sector. But obviously, I'm probably gonna have to take care of them at some point, at some point, some level, because we're not going to be having the capacity to take care of our parents. Yeah. In like 40 years, I think. That scares me.
R: Yeah, I imagine. And is there anything that's not medical related that prevents you from seeking health care when you need? Hmm. And that's because economically reasons is one of the things. Even though the egg and on Dallas not super high, you still think it affects your decision to go to the doctor?

NO06: Yeah, yeah. Because when you hear from other countries as well, it's, it's, yeah, we're a welfare system. And Norway is supposed to have free health care, but still, we have the egg and on them, which is weird, because other countries like England, for example, and Germany don't have that. And it's not necessarily that cheap. The egg and on Dallas as well. No, it's like 3000. Yeah, for a year. Yeah. And that's, I mean, it's not nothing. Yeah, in my opinion, and you have to go to quite a lot of doctor's appointment to manage to get that. You just need to break something once. Yeah. Just break your leg and you're set. From experience.
R: So it's just economic reasons and...
NO06: I mean, yeah. Yeah, I guess so. Maybe a bit about the social norms, because, I mean, it's kind of embarrassing. Yeah, I went to the doctor. Nothing's wrong. Yeah, the whole thing that but who cares? Could be a tiny bit, I would say economic reasons is way more.
R: Yeah. And is there anything else you want to mention about how you feel about the health care systems here? How you've been treated? Good experiences, bad experiences, anything?
NO06: Not that I know. I just think, I don't know. It's difficult to say. I just know that we should. It's easy for me to say this, but we should be able to reduce the amount of patients for each doctor. And also, we should also focus a bit more about mental health. Yeah, because right now it's very, very low, in my opinion.
R: You don't think there's enough?
NO06: No, from my opinion, not my opinion, from what I've heard, if you need public mental health help, you kind of have to be suicidal. And it has gone too far, because do we get to that point? Are we supposed to get to that point before we get help? Because that's usually like the breaking point. And shouldn't we do stuff to prevent getting to that point? And that's terrifying to think that people have to

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R: This is an interview with Norwegian Seven. So we just started a little bit talking about your knowledge of the healthcare system here. Do you know how to properly seek out medical help, like where you should go whenever something happens?
NO07: Yes, I do. I also have two children. So for me, I have had a lot of encounters with the Norwegian medical system. So I know where to find both help and also to seek treatment for myself or the children.
R: And finding information on where to go, everything you find that's easily accessible?
NO07: Yeah, I think if you're used to it, it's more easily. But if I were to think like if I was totally new to it, then it would not be so easily maybe. I like the HelseNorge app. My doctor's office has just switched to this HelseNorge total package app where you can log in. And then I have all the information there on every vaccine I've ever taken from birth until now. And you know, everything, hospital records. Yeah, it's more transparent now than it was before.
R: So you feel like there's a good transparency of your data now.
NO07: I feel very easy to access. I feel so because I had some encounters with, you know, what's it called? In my youth, I went to a psychologist for mental health issues. I had a dad who was an alcoholic. So I had troubles in my youth. And then I had my mother arrange for me to go to a psychiatrist. And I didn't have access to those files. But when I got the HelseNorge, I got logged in there. Then you can see. Then you can see. Yeah, yeah. Then I can't read everything, but I can access when I was there and some about what was it about.
R:And before you had access, you mentioned that you have access now, but it wasn't always like that. What did it make you feel when you didn't have any access to your own medical information?
NO07: It feels kind of hurtful, maybe, because, you know, all the medical files, you know, the things the doctors write, everything. It's personal. It's my life. It's about me. So I kind of I like when it's more open, transparent before it's not. One thing I do like is that now when you you're

pregnant in Norway and you give birth to a child, you have more dialogue with, you know, the hospital before birth and also after. And then I received like an epic risa. I received the paper about the birth itself that I liked because when you're giving birth, you like you get lost. You don't remember. And then you wake up like the day after and like, oh, what did I actually say about the day like I had some damage? Maybe they need to sew up something. What did the person say? You don't remember, you know? And now I like that you get this information. But my sister, who's seven years older, she didn't get that with her children. So she was like, that's that's new. And she liked that. So you like the fact that you're personal. Yeah. They have a little bit more autonomy over your own health. Yeah, especially when it comes to childbirth. Yeah. Not so much other things. When I think about it, you know, when you go to the doctor for anything else, you're like, they're very you don't feel like you have so much to say. You know, you feel like the appointments are kind of rushed. Yeah, of course. They have a limited time. Yeah. They're always late. I have like I had the same doctor now for maybe, oh, maybe 10 years. Yeah. She knows me well, you know, always when I book an appointment, it's like three weeks in ahead. Yeah, they're always late. She's always she tries to make time for me and like see me when I come into the office. But I know she's stressed. Things go very quickly.
R: You have to prepare.
NO07: Yeah. You have to prepare what you're going to ask the doctor, what you want. It goes. Yeah. How do you feel about that? The fact that it takes three weeks to get an appointment and you do get there is everything. Yeah. You feel like you don't want to bother them. Yeah. You know, so you get a feeling that, OK, I have this problem, I sick or whatever, but I don't want to bother the doctor. You feel like you're an inconvenience.
R: Yeah. Yeah, you do.
NO07: Yeah. And also, but I think that's pretty much I have talked to my friends about this also. And they are like, oh, my doctor is so impolite and he's like boom, boom, boom. But some doctors are like more talking to you as a person, seeing you as an individual. I think it's very different. Yeah. From doctor to doctor, you know. Yeah. It changes. It's persons, you know. So person to person. Because here in Norway, you can you can go into fastlege.no or something. You can write and you can read what other people have read of the doctor. Have you seen that? It's like a rating.
R: Yeah. You know, yeah.
NO07: And then there are a lot of different opinions. And I think most doctors are like a little scared of that because they want to like have a good rating. Yeah. That's kind of crazy.
R: Yeah. And have you ever had any difficulties understanding how to properly use the medical services available here?
NO07: No. No. I think it's pretty straightforward, you know. Yeah. It's easy to know, especially when you have children, they have free health care, you know. So they also have something that you get it automatically. You know, when they're little, you have like a doctor's appointments when they're four years old, when they're this and this years old, and you get a lot of information. And they communicate with the hospitals if there's something about maybe hearing or sight or something. So I feel that's very easy. Yeah. But maybe as an adult, it's more like you have to look up the information yourself. So it's a little bit more work.
R: Yeah. Yeah, I think so.
NO07: And also, it can be expensive for some things because there's not everything that's covered by the, what's it called?
R: Public system.
NO07: Public system, yeah. Some things are not. Yeah. That's also something I've thought about a lot of times. I think it should be more covered, you know. Yeah. Like chiropractors or if you have like physical therapy or also, yeah, a lot of other things. I feel like this should be included, you know.

R: Yeah, it should be a part of it as well. It's also health, you know.
NO07: It's also health, yeah, absolutely. Same for gynecologists. Yeah. You know, there are some gynecologists that are under the public health care, but the waiting list is so long. Yeah. So when it's so long, it takes, yeah, you go to the private ones, you know, and then it's very expensive and shouldn't be like that. No. No.
R: And do you know which health care systems are available and how to reach them? Like Blagevakt, Hälsostation, everything.
NO07: Yeah, you need to go online, of course. Yeah. And then you need to like find the specific ones. There should be like one web page would be better. Yeah, or one like more for your region maybe. Yeah. Kristendom Kommune maybe has something, but I think Blagevakt, they recently changed their number, I know. So now it's like one number for every region in Norway, and then they just direct you. Yeah. Yeah, so that's pretty easy, I think. Yeah, that was better than the way they were before.
R: That's good. Yeah. Improvement. Improvement.
NO07: Oh, it's good. Yes, yes.
R: What do you usually seek out, like a doctor or medical help?
NO07: Yeah, I'm smiling because that is very typical of me of waiting a very long time because I think, ah, this will be okay, you know, or I'll think it's probably nothing. Yeah. That's very typical of me. I had an incident a few years ago where I thought I was having some back pains, and I thought, oh, I've been working much, and I have after my children, I had like back in listening, I had like problematic. Yeah. Yeah. And I thought, yeah, yeah. And I had some fever. Oh, it's okay. It's probably okay. I don't want to bother anyone. And my friend was like, you have to go to the doctor. I was like, no, this will be okay. And later that night, I got a really high fever, was rushed to the hospital, had what's it called kidney inflammation. And yeah, I was hospitalized for days. And they were like, why didn't you like come before? Yeah, but I think it's like a female thing. Yeah. I just endure. I think it's okay. Yeah. I don't want to bother anyone. It will get better by itself. And I also thought because of it was like after birth pain. Yeah. You feel more like I should take this. Yeah. Yeah. I think it's very typical of women to think like, we just have to. We just have to deal with the pain. Yeah. Or just like, ah, it's probably not a big deal. Yeah. And then the doctors were like, it's a very big deal. You shouldn't go with that most pain or fever. Or I had to have like antibiotics. And yeah. But then it was good. And then I got a very good follow up. Yeah. Yeah. Yeah. From the public health. They were very good to follow me up.
R: And do you think that you usually receive enough follow up and feedback about your health? Or was it just that specific case?
NO07: I think maybe this was just a specific case. Yeah. In general, you don't feel like. No. In general, it's like, and that's been also an issue with childbirth, especially because the labor capacity is so limited. Yeah. So when you go into labor in Kösslandsam hospital, it's like you're out the next day or maybe the same day. It's like, okay, everything is fine. You go. So you don't get that much attention or help as you maybe would have wanted. And when I talked to my mother, she had me in the 80s. She was like, oh, we were in the hospital for a week and we got a lot of care from the nurses with the baby. And she said there were a lot of much more follow up and care both for the woman who gave birth, but also for the babies. But now it's like when you have your baby, it's like, okay, you are alone and they don't have the time for you. Yeah. So I know from a fact, many of my friends or people I know have had postpartum depressions, you know? Yeah. And I think maybe that could be a correlation or something about that since they, because of the way the healthcare system meets you, you know, right at that moment where you had a baby, you're pretty fragile or vulnerable. You're very vulnerable and everything is completely new. And suddenly there's a lot of people, the baby comes out and then you're like, okay, you're alone. And then you lie in a room with another woman who's also

crying is like, oh, what's happening? And yeah, you're alone. Yeah. So some things I think maybe were better before, but I think it has to do with capacity.
R: Yeah. I think there are staffing problems.
NO07: Yeah. Staffing. Yeah. So you can see the nurses are very friendly and wants to help, but they just, they don't have the time. Yeah. So it has to be very stressful, I think also for them to work in that system, you know? Maybe they can't provide the level of service that they would like. Care. Because, you know, in healthcare, I think it's about people seeing one another, you know? How are you? How are you doing?
R: And is there anything that's not medical related that can prevent you from seeking medical care when you need it?
NO07: No. I think it's easy to find, you know, both if you go online, if you...
R: But like, if you think you're going to spend a lot of money or, you know...
NO07: No, I don't worry about that in particular, especially if it's like I can go to my doctor, because then it's just like a small fee. But I would say if I were to need like a chiropractor, I would think twice because of the expense. Yeah. Yeah. And I'm a full-time parent and yeah, full-time mom. I don't... I don't... I wouldn't allow myself to spend money on it. And that's pretty... I can hear myself say it and thinking that's kind of stupid because it's important to take care of yourself, you know? But... So that's why I really hope in the future and I would vote for the politician who would want to incorporate those things in the health system. Yeah. Because I think it's needed. Of course, because there's a lot more to your health than just the fast leg.
R: Yeah, yeah, yeah. Yeah, yeah. And a little bit about your relationship with your fast leg. Have you ever changed your fast leg here?
NO07: Yeah.
R: Why did you change it?
NO07: I changed two times. One time was because my fast leg, poor thing, she got Alzheimer's. Oh. So she had early, early Alzheimer's and I went to her for something and I could notice something was wrong and I wasn't... Then we didn't know, you know, what it was, but I thought like, oh, she hasn't... She didn't recognize me or she was just so stressed. Yeah. So I was like, oh, I think maybe I should change. So I changed then and then I learned, of course, that she was sick and yeah. And then I got a male fast leg and he was very... He didn't... I didn't feel like we connected or like he listened to me. Yeah. You know, I don't want to be like that. I just want a female doctor because it's not about that really. But it was about... He was just so different from me and he didn't, you know, listen to my... I've had some problems with my menstruation and a lot of pains and wanted to know, like, get a hand listening to a gynecologist. And yeah, and he was just like, oh, that's normal. And I was like, no, I feel like this is not normal.
R: So he was very dismissive of you.
NO07: Yeah, he was very dismissive of every kind of like, yeah, female health issues. And I thought that he doesn't understand, you know. And I, after a few... I'm not that much at the doctors. But also when it came to the children, he was very like, I don't go to the doctor every time my children has a fever. But if they have a fever over a specific period of time or I see that they maybe they need some help, I go to the doctor and he was like very... And it ended up in the lägevakt. Yeah. And then they were like, oh, they have an infection. They needed medicine. Yeah. I was like, oh, that could... The fastläge, he could have picked that up. Yeah. So I changed to the one I have now.
R: Yeah. And do you trust the one you have now?
NO07: Yeah, very much. I feel like she is very nice. And we also have this opportunity now in the Hälsynorge app to like chat. Yeah. Send messages to each other. And I like that because then I had some cellular changes in my cervix. You know, like the step before you get cancer. Yeah. And she was like very... She sent me a lot of messages each time I had a new test. Not

only just to say that it was negative, but a little bit around it. And I like that, you know, I feel like... I feel like... And also since I had her a long time, I feel like I know her. And yeah.
R: You built a relationship.
NO07: Yeah, I built a relationship with her. And I feel like she listens to me and that she...
R: Yeah. That's important, I think.
NO07: Yeah, that's very important.
R: Yeah, yeah, yeah. And do you feel comfortable sharing any type of information that can affect your health and treatment with her?
NO07: Yeah, yeah. I'm an open book type of person. Yeah. So it's not a problem.
R: And I also think that it's important to be honest, you know, with your... With your doctor.
NO07: Yeah, with your health professional. In any type, I think it's important because it only affects you if you don't say it.
R: Is there anything you would like to change about your relationship with her?
NO07: No, I don't think so. It would be nice if she had a little bit more time, you know, if I didn't have to wait three weeks for something. Yeah. I know that if something is more urgent, yeah, I would probably get an earlier appointment and such. But I think that most doctors today have too many patients. I think that's an overall issue, you know. There are not enough fast legge. Yeah. So I think they have a lot of work pressure. Yeah. And you can see that. So it's not necessarily the fast legge fault.
R: No, no. It's more like a system.
NO07: Yeah, I think it's a system fault because you read about it in the paper. You see that, okay, this is an issue. And they have too many patients. They're pressed for time, you know.
R: And that affects the care, you know, the quality of the doctor's appointments,
NO07: I think. Yeah. Absolutely.
R: Do you feel that medical personnel here as a whole, like, has been forthcoming and has provided you with enough information to make good informed decisions about your health?
NO07: That's a good question. No, I don't always think that. I think they are very prone to, like, give you the information about services they use or the services that they like or, you know, not so much about the entirety of what's out there, you know, especially in mental health. The city has a lot of low threshold offerings, you know, for people who have problems with depressions or something. And most of these offers I have found myself, but I did not find them through my doctor, especially when I asked her, do you know anything that is kind of low threshold? Because if you want to go to a psychiatrist nowadays, there's a long waiting list, very long waiting list. And so I was like, I just need something now, you know. And then, yeah, she didn't provide me that information. And I was wondering, is that because she don't know them or is that because she maybe is more inclined to know, you like, give information about the other stuff? Yeah. Hi. But I'm not sure. Not sure what's the reasoning, but that could be better. It could be better.
R: Yeah, it could be better. Absolutely. And do you believe that the medical treatment you receive here is adequate to your needs?
NO07: Yeah. Yeah. Yeah, I think so. Absolutely. I think there's a lot of other countries where it's worse. Yeah. Yeah. So I'm appreciative, very appreciative of the medical care. Yeah. Especially the public ones.
R: Yeah. Yeah. And in your perspective, like, how does the health care system here affect your everyday life? Does it make you feel safe? Does it make you feel anxious?
NO07: Oh, yeah, it makes me feel safe, especially when it comes to, you know, the children and their medical offerings. Because the school system has their own, you know, health system, which is nice. So I feel safe. I feel safe that they are good, taken care of. Yeah. And also that in the everyday life, they follow up everything. Yeah. Yeah, yeah, yeah.
R: Very good. So the public system is much better when you're underage.

NO07: Yeah. I think that. After you become an adult, it's like now you're on your own. Yeah, yeah, yeah. Because I see with the children, it's like it goes automatically. Yeah. They're very like, they have. They're very proactive with kids. Very, very. But with the adults, it's the opposite. Yeah. When I think about it, that's actually very true, because my daughter, she's like, she has a problem with eating. She doesn't like to eat. So she's a bit on the skinny side, you know. And when they have like this weight and height measurements, she always falls below. And then the health system was very like, oh, we can just try this and this. And I got a lot of help, you know, also with the hospital and a naryngophysiologist. And they were so good at providing her everything that we needed. So and also like this nutritional drinks. Yeah. I got on Blue Recept, you know, that's free. Yeah. Yeah, for her. And they cost like 58 kroners per. Very expensive. So I was like, oh, and she has to have like two a day.
R: That's a lot of money.
NO07: That's a lot of money. I was very happy when my doctor was like, no, no, we get like, she gets that for free.
R: That's really good.
NO07: Yeah. So some things are like, and that just came automatically. Yeah. You know. But how do you feel that like for kids, it's very good. But when you're grown up, like. I don't think that's the same. No. Yeah. I think maybe then you have to be more proactive yourself. You know, you have to be the one that pushes to get things done. Like I was a gynecologist. I had to be like, but I want this and this. I had to like press for the things to happen to get the help I needed.
R: And what do you think about that?
NO07: That you have to. That's not good. Yeah. You know, I think, I think our health system should be different. Yeah. In that way, because many people, I think, especially young adults, they don't maybe take care of themselves in the best way. Yeah. And they don't really know where to go to find this help or when they need to like be more proactive themselves. They fall between chairs and like, okay, nevermind. Everything will be fine. Yeah. So they should maybe do something from the system. Yeah. In. To help with that. Yeah.
R: Yeah. And is there anything else you want to mention? Like a good experience, bad experience, your perspective of how your treatment has been here. Have you ever felt that because you're a woman, you were dismissed or something?
NO07: That's a hard question. No, I don't think I have been dismissed because I was a woman, but I have, like I said earlier, the experience of when you have like female health issues. Yeah. It can be difficult to be heard and seen, especially if you have a male physician who's not particularly maybe aware. You know, I have a male gynecologist and he's very good. Yeah. He's very attentive. He listens. He takes everything into account. But some of the male fast leg doctors, they don't maybe understand or take it as serious or. Yeah. So in that regard, I have maybe felt that, but not not in any other sense, you know, with other problems or. Yeah. It's just the same.
R: And that's a good thing. Yeah. Yeah. Yeah. Very good. Yeah. It's very good. Well, that was it. Yeah.

INTERVIEW NORWEGIAN 08
R: So this is an interview with Norwegian 8. So we're just going to talk a little bit about your knowledge of the healthcare system first. Do you know the channels that you can use to seek out medical care?
NO08: I contact my doctor through Helsenorge. And there's a booking system where I can get the appointments.
R: That's all you know?

NO08: Depends on what I'm going to do. But there's always like you can Google the service you want and they have a phone you can call or a booking site.
R: So you just go to Google and see what you need at that moment. And have you ever had any difficulties understanding how to properly use the medical systems that are available?
NO08: To get the appointment?
R: Yeah, to get the appointment, to reach out to the fast legge, to go to the leggevac, any difficulties understanding how it works?
NO08: No.
R: Do you think it's very straightforward and everything?
NO08: Yeah, you can find the information you need mostly on their websites.
R: And you know all the websites and everything?
NO08: I think so.
R: So you know which healthcare systems are available and how to reach each of them like leggevac, fast legge, everything you need.
NO08: Yeah.
R: You feel very comfortable navigating the system.
NO08: Yeah.
R: And usually how long after you present symptoms do you seek out medical help?
NO08: Maybe three, depends a little, but maybe like three days.
R: Yeah. Why do you think you take three days before you look for it?
NO08: I wait to see if it will pass by itself. Yeah. And it also depends of course on what it is, but if I get sick I usually just wait to see if it will pass and if it doesn't or it gets worse, then I will check if they have an appointment. Maybe I can come. Yeah.
R: And do you find that it's easy to seek it out when you need it?
NO08: Yeah,
R: Appointment and everything?
NO08: Not always actually. Sometimes I have called and you sort of have to like argue that it's urgent. Yeah. So it's not always easy to get if you need an urgent appointment. Yeah.
R: And what do you think about that, that you have to kind of argue that you actually need help for them to...
NO08: Yeah, you need to like argue that it's actually urgent, that you can't wait for longer. Because then I've maybe already had the symptoms for a couple of days and then I'm not interested in going another week to get the appointment.
R: And how does it make you feel, the fact that you have to kind of fight to get the appointment?
NO08: I get really stressed and I hate conflict and I'm really a people pleaser so I'm like, it's okay, I can wait, but I don't want to wait. So then I have to... Yeah. It feels uncomfortable.
R: It feels uncomfortable to have to go through that, jump through hoops.
NO08: Yeah.
R: And have you ever changed your fast leg?
NO08: Yes.
R: And why did you change your fast leg?
NO08: Because she didn't really seem interested in checking out my symptoms when I got there with the problem. And she also prescribed me things when I didn't feel like she checked out the problem, probably. And she just wrote me medicine and I was like, is this really what I need? Mm-hmm. And so I didn't like her, so I changed.
R: Yeah, so you didn't feel comfortable with her, you didn't feel like she heard you at all.
NO08: No.
R: Yeah. And do you have a new fast leg now? Is he a man or is she a woman?
NO08: I want to change to a woman and I did and then she actually got sick met. Yeah. So I have never been to her, I've only been to her subs.

R: Yeah. And then do you trust the subs?
NO08: No.
R: Do you trust your fast leg?
NO08: I think he's really bad.
R: Why? Why do you think he's really bad?
NO08: I don't know, he just, some of the things I've been coming there for has been like health care for women issues. Yeah. And I feel like he doesn't understand, he's just like, I feel like he's kind of googling. Yeah. And I feel like I could do that myself too. And some of the questions I had he doesn't know the answer to.
R: And how does he act when he doesn't know the answer to? He... Does he tell you, yeah, I don't know the answer or
NO08: Yeah, yeah, sometimes he does and sometimes he just like, what's the English word? He just says some things that he thinks but it's not really the answer to my question.
R: Yeah, yeah, he just goes around in circles.
NO08: Yeah, he just... Sort of. Yeah, yeah. Yeah.
R: So you don't feel like he hears you, like hears your concerns and your...
NO08: No, I feel like he tries but I feel like he just don't make it.
R: And do you feel comfortable sharing any type of information that can affect your health with him or your treatment?
NO08: Yeah, I feel like I trust that he's a healthcare person working in... Like, I feel like it's no problem telling him but I feel like he just maybe... Maybe it also is like his experience that he hasn't really...
R: And like you mentioned that he usually doesn't have the answers and it's usually, you know, related to, you know, reproduction or, you know, female systems. Has he ever referred you to a gynecologist or, you know, to someone that would be more knowledgeable?
NO08: No.
R: And do you feel like he should have referred you to...
NO08: I feel like he maybe should have... Yeah, maybe thought of the possibility and he could have like asked me if I wanted to see someone else who maybe knew a little bit more about it. Yeah. But I didn't ask either because I'm shy.
R: Because you're shy. Yeah. So you just don't feel like advocating for yourself in a way.
NO08: No. And I also feel like when I'm there it's like they want to be quick. Yeah. Yeah.
R: So you just feel like you're taking their time.
NO08: Yeah. I feel like sometimes if you like notice that they're like actually late and have another one waiting. Yeah. You don't want to sit there and be like, but maybe could I do this? Could I get this?
R: So you just don't want to bother them too much.
NO08: Yeah. Yeah. Yeah.
R: And is there anything you would like to change regarding your relationship with your first legger? Or your sub?
NO08: Right now I don't have a first legger because she quit. And now I don't know if I even can go to the sub that I used to see. Yeah. But of course I have someone I can go to. But I think I got a new first legger in Vågsbygd. Yeah. And I'm on the waiting list to another one.
R: What do you feel about that being like up in the air with your first legger?
NO08: It's not that great. But I could have probably gotten a new one. But I really want, I wanted a woman because I had a man at home. And I also feel like he was very bad with everything concerning female problems. Yeah. So I wanted a woman. And it's not very many women who are available in Kristiansland. Yeah.

R: And do you feel that the medical personnel here is forthcoming and provides you enough information? So that you can make informed decisions about your health and treatments, treatment options and things like that?
NO08: They could have taken the time to describe it a little bit more. Yeah. Especially the first one I had here. She just got, she was just like giving me notes like by this. And not really telling me how to use it or what it, how long until it would get better. So most of the information I have received for like medications and stuff I have received at the pharmacy.
R: At the pharmacy.
NO08: And that's okay because they have given me very good information.
R: But do you feel like the doctors should have a little bit more of a role in that?
NO08: Yeah. Yeah.
R: And what do you feel about that? That like the doctor kind of just pushes that role away and doesn't take the time to properly.
NO08: I feel like it would be great if they could just like end the session with, do you have any questions? Yeah. Do you feel like you got everything you need? Yeah.
R: So do you feel they just kind of push you out as soon as they can?
NO08: Yeah. Yeah. I feel like everything is very rushed. Yeah.
R: And do you think that you receive enough feedback about your health? Like answers about exams or you know, something happened and they check on you to see what is happening, if you have improved or anything like that?
NO08: I feel like that's over, that's my responsibility to contact them back if things haven't improved.
R: Yeah. Yeah. So they have never like done that or anything like that?
NO08: No.
R: And you feel like it's on you to go to them?
NO08: Yeah. Yeah.
R: And do you think that you have enough access and transparency about your medical information? Do you know where to go to look for it and everything like that?
NO08: I think most of my information is at my chart at the Helsenorge.
R: And you can access no problem, you find it very easy?
NO08: Yeah. Yeah, I think so.
R: And do you believe that the medical treatment you receive here is adequate to your needs?
NO08: I think I don't go that often to like a healthcare system, but I feel like it could have been more doctors so that every session doesn't feel so rushed. Yeah. And it will be easier to get an appointment if you need a rushed appointment or yeah. You don't have to wait so long to get an appointment every time.
R: Yeah. And how do you feel about this rushed appointment? Like, does it make you feel careful? Does it make you feel like what do you feel that you're always like in a short appointment that you don't have that much time?
N08: It makes me feel like it sucks that I something happened because then I have to go there to get help and they don't seem to actually have the time.
R: Yeah. So does it in a way discourage you from seeking medical help?
NO08: It doesn't make me feel like I'm doesn't really feel like a relief. Yeah. I think it would be nice if it felt like if something happened to you and you go to the doctor and then you feel like it really helped. Yeah. But it doesn't really feel like that. No. What does it feel like when you go to the doctor and it's, yeah.
R: Just feels rushed and a little confusing and a little like did I get the right help for what was going on?

NO08: Yeah. Maybe they could, sometimes I feel like maybe they should have taken more tests. Actually like look at me if I come with like a physical problem. I feel like maybe I feel like they should check it out and not just like listen to me describe it. Yeah. Behind their desk.
R: So in a way you don't think they're proactive enough?
NO08: No. No. Yeah.
R: And you think that would be better if they had like more proactiveness in their care?
NO08: I would feel like it's that they're actually sure it's the thing they're giving me medicine for. Yeah. It's actually what I have. Okay. Yeah.
R: So you feel more comfortable with their decisions if they actually took the time to do everything.
NO08: Yeah.
R: And in your perspective like how does the healthcare systems here affect your everyday life?
NO08: Not a lot unless if it's really if I need an appointment and it's hard to get an appointment when I have the time.
R: Do you ever feel anxious that like you might not be able to get an appointment and you might really need it? Like does it make you feel safe that you know that the healthcare system is there to support you?
NO08: I can feel maybe a little anxious if something happens during like a holiday or something when it's like fastlege is closed and it's more stressful if you have to go to like legevakten. You won't receive help unless it's really bad.
R: And what do you feel like about that that you can receive help at the legevakt? Why do you feel like you can receive help at the legevakt?
NO08: Because they are really short staffed so they only and they take like if you go there and like just have a... I went there once when I was younger and I have... What's it called? Trokket over. Like my ankle.
R: Yeah, you sprained your ankle.
NO08: And then I just had to sit there until no other people were more injured than me. Because they are short staffed and I didn't have my fastlege where I was.
R: So you just feel like the lägevakt, it's only there if you're really serious but if you need it... Hey! So you just feel like the lägevakt unless it's something really seriously, it's not something for you to rely on?
NO08: No.
R: And if you have an issue that you can take with the fastlege when they're back open after a holiday or something, you will just be told that you will have to wait. And what does that make you feel?
NO08: I feel like it's very bad but I feel like the problem is that we just don't have enough people. And money.
R: Well, you have money.
NO08: Yeah, we're not using it.
R: Is there anything that's not medical related that can prevent you from seeking medical help? You mentioned that you wouldn't go to the lägevakt on a holiday if it could wait. Like anything else? Like the location, how easy it is to get to your lägevakt. So if it's not something you completely need, the location will affect it?
NO08: Yeah.
R: And for instance, financially, would that be a problem for you to go to the doctor or lägevakt or anything like that?
NO08: No, I feel like if I need it, I will of course do it. But it's always... it sucks to use money when it's not your fault if you got sick or injured or something like that.

R: And have you ever in any way felt dismissed or not heard by someone because you're a woman? That they just dismiss you because she's just being hysterical or anything like that?
NO08: Yes, I feel like I've struggled with acne from using birth control. And I feel like when I was younger, they were just like, it will pass. And it was hard to get to see a specialist. And it was also hard to... I had to argue that it had bothered me long enough to try some medication, stronger medication.
R: Yeah. And what do you think about that?
NO08: It sucks. I feel like I didn't... it was like... I don't know because I've always been on birth control forever, but I feel like maybe it wouldn't happen if I didn't use that.
R: So one medication caused more problems. Had they ever offered you a different solution, a different medication? Or have they ever investigated why that one reacted that way with you and maybe another one wouldn't?
NO08: No.
R: Have they ever raised that possibility, gave you information about the options that you had?
NO08: No. Everything I've found out, I've been researching myself. And when I didn't get the offer or information that I could change, maybe the birth control instead, they just gave me a different type of medication to put on top of that.
R: So they don't really explain to you everything, they just kind of...
NO08: No. Yeah.
R: What do you think about that? Do you think that's a good way of dealing with the problem?
NO08: No. And I also feel like that's a time issue, that they don't have time to go really thorough, deeper into the problem.
R: Yeah. So kind of everything comes back to the staffing and time constraints.
NO08: I feel like one of the biggest problems to me is the time and of course people working there and resources.
R: Is there anything else you would like to comment on about how you feel about the healthcare? Or good experiences, bad experiences, anything? Things you think could improve?
NO08: When you asked if I've been treated differently because I was a woman, I feel like very many of the men I've seen, they don't know things. And that's why I wanted a female doctor. So that's also bad, that I feel like they don't know enough about women's health. Yeah. That's it.
R: Thank you very much.