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Barriers to Access to Healthcare Services by Immigrants Population in Scandinavia: a systematic scoping review

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ABSTRACT

Background: A universal coverage characterises Scandinavian healthcare systems. The system is financed through taxation. Immigrants with legal residence in Norway, Sweden or Denmark are entitled to the same health coverage as the native population. However, research has shown that despite legal residency, immigrants' utilization of regular healthcare services is low compared to the native population, while the use of emergency services is higher among them. The increased use of emergency services has been associated with various barriers to access to healthcare services. However, there exist a few studies on the issue of access barriers regarding immigrants living in the three Scandinavian countries. This scoping review aims to identify, map, and discuss existing evidence on the barriers to accessing healthcare services by immigrants in Scandinavia.

Methods: This scoping review was conducted based on Arksey and O'Malley methodology framework for undertaking scoping reviews. A search for articles published from 2007 to 2017 in the English language was performed in PubMed, MEDLINE, CINAHL, EMBASE and PsycINFO. The reference lists of the reviewed studies were examined for potentially relevant studies.

Results: A total of 418 articles were identified through searching the literature databases. Fourteen studies were reviewed, and the results were reported using six interrelated themes or concepts identified from the articles. Among the six themes identified, communication and language barriers and culture were the most common barriers impeding access to healthcare services. Further, healthcare providers attitude or response limited access to available information. Unfamiliarity with the healthcare system made navigating the health systems difficult and created distrust in the healthcare providers and systems resulting in increased utilisation of emergency care. Some immigrants were reluctant to seek attention because of fear of stigmatisation, prejudice and deportation due to their health status. Immigrants with a low level of education had reduced understanding or lack of access to available information.

Conclusions: This review has identified and mapped six thematic categories of barriers to accessing healthcare services that may impede access to healthcare by immigrants with legal residence in Scandinavia. Although 78% of studies indicated that communication and

language barriers hindered access to healthcare, and interpreters were often unable bridged the communication gaps, cultural barriers further complicated interactions with care providers. In light of the interrelationship between these barriers, this review recommends that cultural competency is incorporated into the practices of healthcare professionals and systems.

Keywords: Scoping review, healthcare services, access, barriers, immigrants, migrants and Scandinavia

LIST OF ABBREVIATIONS

CASP	Critical Appraisal Skills Programme
CINAHL	Cumulative Index to Nursing and Allied Health Literature
EMBASE	Excerpta Medica Database
ER	Emergency Room
GP	General Practitioner
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
JBI	Joanna Briggs Institute
MEDLINE	Medical Literature Analysis and Retrieval System On-Line
NOU	Norges Offentlige Utredninger
PsycINFO	American Psychological Association
WHO	World Health Organisation

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CHAPTER 1

1 INTRODUCTION

This thesis is a result of the work undertaken to complete the dissertation aspect of a Master's in Public Health at the Arctic University of Tromsø. The introduction section provides an overview of the research context, and the definitions of the population being examined and the rationale for the study. It also outlines the aim and objective of this review.

1.1 Background

Due to increasing globalisation, migration is on the rise, and individuals from different cultures and countries have the possibilities to reside in nations other than their country of origin (1). According to United Nation Migrant Report, international immigrants reached 244 million in 2015 (2). Immigrants leave their countries for various reasons; some migrate to secure employment, escape war and disasters, reunite with their families or get a better education.

Norway, Sweden and Denmark are collectively referred to as Scandinavia. These three countries have many political and social similarities (3). Over the last 40 years, Scandinavian countries, like many other nations in Europe, have experienced a continuous inflow of immigration (4, 5). At the beginning of 2017, immigrants accounted for 16.8% of the total population in Norway (6); and as of January 2016, 12,3% of the entire population of Denmark constituted of immigrants and their descendants (7). In 2016, 23,2% of the total population of Sweden were foreign-born persons (8). The increase in migration to Scandinavia is associated with the gradual opening of the Scandinavian borders, first within the Nordic region and subsequently the EU(4). Before this, immigrants from Turkey and Pakistan were recruited to cover the high need in the labour market in the 1960s -1970s (4).

The rise in immigration to Scandinavia has had an impact on healthcare systems and healthcare professionals in various ways, as well as policymakers. Studies have shown that upon arrival, many migrants have better self-reported health compared to the general native-born, a phenomenon known as "healthy migrant effect" (9, 10). However, after a period in the

host countries the “healthy migrant effect” may wear off, and the health of many immigrants eventually worsen (9). Furthermore, factors such as discrimination, perceived discrimination, racism and environmental factors are associated with the decline in migrants’ health status (4, 9-11). Studies have reported that poor access to health services among migrants contributes to poorer health status and outcomes (12-14).
“Scandinavian health systems” are built on the same principles of universalism and equity, financed primarily through taxation, to promote equal access to adequate health care services for the entire population including immigrants with legal residence permits (3, 15, 16).

Immigrants with legal residence are guaranteed the same access to health care as native-born. However, studies have shown inequalities in access to health care exist in practice (17, 18). Factors such as language proficiency, cultural difference, lack of education or knowledge of the system, lower economic status and lack of culturally sensitive health care services have been shown to impede access to healthcare services among the immigrant population (4, 11, 12, 19, 20). On the other hand, immigrants often, tend to utilise emergency services for non-urgent needs (21).
In Scandinavia, both healthcare systems and healthcare providers are faced with diverse cultural traditions, and challenges in providing quality health services to patients with other cultural backgrounds. Immigrant patients have more variation in their medical conditions and expectations (1, 11, 22). Additionally, both the immigrant who have long settled in the host countries tend to face the same challenges in accessing healthcare services as newly arriving migrants (23). Healthcare professionals and immigrants alike, recognise barriers to accessing healthcare services as a risk factor for the deterioration in health experienced by migrants. The delay in accessing healthcare services leads to late diagnosis and delayed treatment, increasing the probability of morbidity significantly. Lack of access to healthcare services by immigrants is poor public health practice, and it represents a concern for the receiving countries because migrants are vulnerable health-wise due to exposure to numerous health hazards before, during and after immigration. Furthermore, lack of access contributes to increased vulnerability for migrants and may lead to more discrimination and health inequalities and higher healthcare costs for migrants (24, 25).

The increasing cultural diversity in Scandinavia creates opportunities and challenges for healthcare professionals, healthcare systems as well as policymakers to provide and deliver culturally competent healthcare services (26). Access to healthcare services is defined

differently in the various research literature. The definition of “access to health care services” ranges from the narrow approach of services entry to the multidimensional approach, which includes: availability, accessibility, affordability, acceptability and accommodation (27). According to Gulliford et al. (28), the opportunity for a community to gain access to healthcare services exist only if the services are available and supplied adequately, and the extent to which access is obtained depends on organisational, social, financial and cultural barriers. Hence, identifying barriers to accessing healthcare services and understanding factors that can influence access to services may improve the delivery of primary and secondary healthcare services to immigrants with legal residence in Scandinavia.

1.2 Definitions

Scandinavian countries do not have a uniform definition for immigrants. Denmark and Norway look at the country of birth of an individual and their parent when defining migrants, whereas Sweden uses “foreign-born” when describing immigrants in its official statistics. Norway and Denmark see immigrants as persons born abroad of two foreign-born parents (4). Additionally, Denmark takes the absence of information on one or both foreign-born parents into account in their definition of immigrants (29, 30). For Sweden, a foreign-born is a person with a legal admittance, who is expected to stay a minimum of 12 months in the country (31). Migrants refer to individuals who have migrated from one nation to another, temporally or permanently. This term is not applicable to students or tourists (32). This review focuses on legal immigrants. An immigrant with legal residence is a person who has a right to enter, settle and work in a country with no restrictions and has the same rights and obligations as the native population (33). For the purpose of this review, an immigrant or migrant is a person with legal residence in Scandinavian countries.

1.3 Study Rationale

Scandinavian nations have a tax paid healthcare system where the state funds the services. There is a user fee that is paid to the general practitioner (GP) as consultation cost. The unique funding mechanism improves health service provision while ensuring that healthcare services coverage is universal (34). According to NOU (Norges Offentlige Utredninger) (35), access barriers can have direct consequences on the outcome of treatment. Access to

healthcare services is key to improving health outcomes. Although immigrant population have better self-reported health status upon arrival, this health advantage wears-off with the length of stay and acculturation and their health seem to decline leading to a low self-report health status. This phenomenon is associated with factors such as poverty, low-education, stress and discrimination (36). Self-reported health status is the primary predictor of health services utilisation, morbidity and mortality (19). According to Akhavan, the lower use of well-documented medical treatments for immigrants compared to native Swedes with conditions such as heart failure, heart attack, stroke and chronic obstructive pulmonary diseases, indicates unequal treatment within the Swedish healthcare sector (19). Håkonsen et al.(37), stated that immigrants receive less treatment compared to native Norwegians despite regular contact with the healthcare system. The duration of stay, country of origin, literacy level, language skills and residency status has been the contributing factors towards healthcare access and utilisation (5). Improving access to healthcare services of immigrants remains a key factor in making health outcomes better within the Scandinavian nations.

Studies have shown that migration renders immigrants more vulnerable to health hazards and stressful situations and may lead to stress reactions and risk behaviours. Immigrants also tend to adopt both healthy and unhealthy lifestyle and practices of the native population. Poor eating habits and more sedentary lifestyle are examples of unhealthy practices which immigrants tend to adopt. Such practices make them more susceptible to lifestyle-related conditions and increased health disparities (16, 38). There is some evidence to show that conditions like diabetes, hypertension, cardiovascular diseases and cancer are becoming more common in the immigrant populations; as a result, there is an increasing demand on the health systems of the host countries (39).

Governments in Scandinavia recognise the need for cultural competency among healthcare professionals as they are required to ensure equal access to care services to their patients (3, 40, 41). One of the aims of the Norwegian government is to ensure that healthcare providers acquire knowledge on immigrants' cultural backgrounds and cultural challenges associated with ensuring them equal access to healthcare services (40). Danish healthcare authorities stated that immigrants' insufficient language skills and inability to communicate comprehensively in the Danish language might limit their ability to navigate the health system (41). The Danish health authorities also recognise challenges healthcare professionals are faced with due to language barriers when in contact with immigrants who do not speak and or

understand the Danish language enough to respond to information about, for example, the nature of symptom, diagnosis and treatment option. This often leads to frustrations and insecurity among healthcare professionals (41).

A report by the Danish health authority stated that several Danish and international studies had described challenges experienced by healthcare professionals due to language barriers (41). However, most of the studies identified through a search of the databases for this review included asylum seekers and, or undocumented immigrants in their sample. Only a few studies focused on barriers to accessing healthcare by immigrants with legal residence in Scandinavia. This suggests that there exists a gap on why the immigrants with legal residency in Scandinavian countries do not have the same access to healthcare services as the native population. Hence, identifying and mapping the nature and extent of evidence available may highlight the barriers to accessing healthcare and services in the existing literature, which may lead to more research and policies that will ensure immigrants equal access to healthcare services.

1.4 Study aim and objective

The purpose of this scoping review is to identify and map existing evidence on barriers to access to healthcare services in general by immigrants in Scandinavia. This scoping review was written by the primary author, with the contribution of two external reviewers (K. A. and O.O.). K.A. has master's in public health and epidemiology, and O.O. has Masters in Public Health, and he is a PhD fellow. K.A contributed to the selection of the final articles and retrieval of the relevant data from the studies included for the final analysis in this review and O.O. was the tiebreaker. This was to minimise bias and for the trustworthiness of findings of the review.

1.5 Thesis structure

The thesis is structured into five chapters. Chapter One covers the introduction and provides an overview of the research context, the rationale for the study and the aim and objective of the review. Chapter Two explain the research process by presenting an outline of the methods, and justification for choices of methodology. Chapter Three shows the results. Chapter Four covers the discussion of the results and the methodological considerations. Chapter Five presents conclusions and provides recommendations.

CHAPTER 2

This chapter outlines the methods according to Arksey and O'Malley framework for conducting scoping reviews, and the recommendations proposed by other authors towards this approach and the justification for the choice of methodology.

2 STUDY METHODS

Existing publications can be utilised to produce a research with different aspects considered. Scoping review also known as scoping study refers to a knowledge synthesis that addresses an exploration type of research questions. Scoping reviews aim to identify, and map fundamental concepts, evidence and gaps related to an area of interest. A systematic search is done followed by the selection, synthesis of existing knowledge and reporting the findings (42).

This review is guided by the Arksey and O'Malley framework for undertaking scoping review and by other authors who have made recommendations for improvement of this approach (43-46). The Arksey and O'Malley frame work for performing scoping review has 5 stages and an optional 6th stage. The five-stage framework includes: (i) identify the research question, (ii) determine relevant studies, (iii) selecting studies, (iv) charting data and (v) collating, summarising and reporting the results (43). The optional sixth framework (consultation exercise) was not included in this study.

Scoping review provides a descriptive account of available research. A typical scoping review does not attempt to appraise the quality of deducted evidence in primary reports following the Arksey and O'Malley framework (43). Furthermore, the inclusion of the recommendations by other authors allows for quality assessment (45-47). As suggested by Grant and Booth, lack of quality assessment limits the implementation of scoping review results into policy and practice (46). Hence, the decision to assess the quality of studies included in the review, thereby, allowing for recommendations based on findings from the study.

2.1 Justification of Methodology

The family of reviews includes systematic review, rapid, realist and scoping reviews. They capitalise on time and urgency, interventions effectiveness, how and why complex social interventions work (43). The qualitative and quantitative research done on the topic of interest

has few articles that can be used for a systematic review because articles of low quality may be removed in a systematic review, while all studies that meet inclusion criteria are included in scoping review irrespective of the quality of the article. In a scoping review, all available literature, reports and commentaries on a subject or field can be included in the research, making it possible to achieve in-depth and a broad result. The study topic has very few associated published and grey literature (46). The barrier to healthcare services among immigrants with legal residency is a complex area with few previously reviewed comprehensive details. Based on this deficit, scoping review is helpful to answer the research questions with complex areas with less review (43). The author believes that through this scoping study, more information will be added to existing factors that act as barriers to healthcare systems among the immigrants within the Scandinavian nations.

2.2 Stage 1: research question

The purpose of scoping reviews is to achieve in-depth and broad results as they endeavour to identify all relevant literature irrespective of study design. Therefore, they necessitate a broad research question, so that potentially useful literature is not excluded (43). To this end, the question posed for this review is:

What are the barriers to access to healthcare services by immigrants in Scandinavia?

2.3 Stage 2: Relevant Studies

This scoping review applied entire field scoping to identify all comprehensive studies and publications relevant to identifying and mapping barriers to accessing healthcare services. Published primary studies were searched for in Medline (Medical Literature Analysis and Retrieval System On-Line), CINAHL (Cumulative Index to Nursing and Allied Health Literature) EBSCOhost, PsycINFO (American Psychological Association) and Ovid EMBASE databases. In trying to answer the study questions and objectives, unpublished work (i.e. grey literature) were also searched for in Google, greylit.org, Google Scholar and WHO website. Different evidence searching mechanisms were applied including an electronic search of databases, reference lists of relevant articles, individual hand searching for major journals and identification of existing networks. Some authors were contacted and conference materials explored to develop the data required.

The initial search not limited by publication year yielded a large hit with many articles that were irrelevant to this review. Hence to minimise the numbers of studies to a more manageable numbers, considering the time required to examine each article identified, the search was limited to articles published from 2007 to 2017. Most studies found were in in the English language a decision was therefore taken to include only articles published in the English language in this review. The scarcity of Norwegian, Danish and Swedish language materials on the research topic, combined with the required costs for translation was the primary factor for English language preference.

2.3.1 Electronic databases and internet search

Primary data sources including Ovid Medline, CINAHL, EBSCOhost, PsycINFO and Ovid EMBASE databases were used. Additionally, PubMed for academic articles, google scholar and WHO website was also searched. Individual university libraries were included in the search, and grey literature database (organized by the New York Academy of Medicine Library) were examined for grey literature. A specific online site for grey literature greylit.org was used with university websites providing some of the unpublished work. Access to charged sites was made available through the University of Tromsø library.

Different search sites had various materials with other key terms used. Using research questions and key concept definitions with guidance from different libraries, the author formulated tailor-made search methods for each site. Only four databases were able to generate articles of interest for this study. A single uniform search formulation to fit all databases was not utilized due to the different outcomes and combinations. Finally, to explore all potential sources of information, the reference lists of all selected articles were scanned for relevant articles. Studies identified through all the searching process were imported into a bibliographic database (Endnote version X8) for storage and screening of the Papers and to keep track of the abstracts, citations and review process.

The search strategy and medical subject heading (MeSH) terms, as well as keywords for the literature search, applied in PubMed, were: (“immigrant”) OR migrant) OR emigrant) OR foreign-born) OR alien)) AND (health care access) OR (healthcare) AND access barrier) OR (primary health care) AND access impediment) OR general practitioner) OR dental care) OR ((healthcare services) AND barriers)) OR “barrier”) AND (Scandinavia) OR Norway) OR Sweden) OR Denmark).

The search strategy and medical subject heading (MeSH) terms, as well as keywords used for the literature search, are listed in Table 1. For complete details of the search strategy for the databases, see *appendix 1-5.*

Table 1: Search strategy for barriers to access to healthcare services

Population		
1. Immigrant	16. Healthcare delivery	30. healthcare utilization
2. Migrant	17. 71 – 16/ OR	31. availability
3. Emigrant	***Barriers***	32. affordability
4. Foreign-born	18. Barrier*	33. accessibility
5. Emigration or immigration	19. Impediment	***Access***
6. 1 – 5/ OR	20. Challenge*	34. health services
Healthcare services	21. Obstacles*	35. access to information
7. Primary healthcare	22. Hurdle*	36. healthcare delivery
8. Secondary healthcare	23. Difficult*	37. 29 – 42/ OR
9. Community care/or home care/ or nursing home	24. Issue*	***Country***
10. General practitioner	25. Mistrust	38. Scandinavia
11. Family doctor	26. inequality	39. Norway
12. Mental healthcare	27. obstruction	40. Sweden
13. Dental care/ oral health	28. 18 – 17/ OR	41. Denmark
14. Emergency services	***Access***	42. 1 – 4/ OR
15. Healthcare services access	29. Healthcare access	43. 6 AND 17 AND 28 AND 37 AND 42

Each of the databases searched had a different number of generated references, but only PubMed, Ovid Medline, CINAHL and Ovid EMBASE contributed articles to the final analysis. See Fig. 1.

2.3.2 Reference lists

Articles with relevant information, systematic reviews close to the topic of interest were cross-checked. Valuable bibliography materials were found on references and bibliography. The electronic databases, bibliography and references were further scrutinised to identify all relevant articles. More scrutiny was done to identified all relevant studies until saturation was achieved. The citations yielded few relevant studies which were considered.

2.3.3 Hand-searching of key journals

Key journals were hand searched for any relevant articles that could be used for this research. This was done considering the deficits of an electronic database that may not be complete and updated. The three nations under consideration had few articles compared to the rest of the world. The University of Tromsø library had stored hard copies of literature (journals) which were searched for matching articles.

2.3.4 Existing networks and conference materials

Some of the authors of the article were contacted as part of networking. They were able to make referrals on other authors who had contributed to studies that were part of the literature. Two authors were contacted for the full text of their articles, but none of the articles was in the English language. One of the article was in the Danish language and the other in the Swedish language. Hence, the articles were not included in this review.

2.4 Stage 3: study selection

The initial search from the sources produced a considerable number of both relevant and irrelevant articles. A specific mechanism was laid to retain what could answer the research questions at the onset of the study. The author also had a post hoc based criteria after assessments of the articles that were identified (44). Inclusion criteria were studies, commentaries or reports related to the experiences of barriers to access to healthcare services by immigrants in Scandinavia. There was no discrimination of study types with the inclusion of all research articles that were quantitative, qualitative and mixed methods. The main content was immigrants with legal residence as the sample population while focusing on barriers to accessing health services. The countries of interest were Scandinavian nations

which consist of Norway, Sweden and Denmark. Studies in Danish, Swedish, Norwegian and other languages were not retained as the researcher could only utilise articles written in the English language. Papers that included asylum-seekers and undocumented immigrants in their research were not included given that the health policy and cover these groups are different and their experiences are more complicated compared to the general immigrant population in Scandinavia (48, 49).

All collected articles abstracts were printed in hard copies or added to Endnote software. The researcher took a chance of contacting some authors for further assistance on missing papers of interest through emails. The main author and one of the external reviewer (K.A) applied the inclusion and exclusion criteria to all abstracts to obtain the best fit that could answer the research questions. If the abstract was not clear, full articles were retrieved by reading the entire edition. The process took three weeks after which there was no more inclusion after the given period.

The next stage involved the reviewers reading through all allocated articles as indicated in the results format. The retrieved articles came from different sources including unpublished work. Research articles and literature that did not meet the criteria were discussed between the two readers. A decision was made on whether to include them as part of data. Where there was no agreement, the article was sent to a second external reviewer, (O.O.) who acted as a tiebreaker.

2.4.1 Criterion Statement

The researcher adopted a weighing system developed by Higginbottom et al., the weighing system consists of three levels: High, Medium and Low; and a criterion statement which makes it possible for the examination of the analogous contributions of the articles towards the synthesis (50). An article with a rigorous and robust scientific approach, and mainly meeting Joanna Briggs Institute (JBI) benchmarks with a score of 7 or more 'Yes' is evaluated as High. A study is evaluated as Medium if it had some flaws which do not seriously undermine the scientific value and quality of the research conducted, and perhaps scores 5 – 7 'Yes'. A study with serious or fatal flaws and lacking sufficient scientific value, and perhaps scores lesser than 5 'Yes' is evaluated as Low. For Critical Appraisal Skills Programme (CASP), articles that scored 3 – 4 'Yes' were evaluated as Low, 5 -7 'Yes' were scores were evaluated as Medium while papers with 8 -10 'Yes' were evaluated as High.

2.4.2 Quality assessment of articles included

According to Levac et al. (47) and Rumrill et al. (51), scoping reviews typically do not assess the quality of papers included in the analysis since the type of study often contains both quantitative and qualitative studies and information from reports and commentaries from professional meetings. However, Levac et al. (47), argued that the lack of quality assessment could lead to a false conclusion in regards to the nature and extent of the gaps identified. Hence, after screening the full-text articles for eligibility, all included articles were evaluated. The quality of the articles was assessed to ensure the robustness of the synthesis and their methodological quality.

A quality assessment tool by Joanna Briggs Institute (JBI) (52) and Critical Appraisal Skills Programme (CASP) (53)was applied. JBI critical appraisal checklist for analytical cross-sectional studies had 8 questions, each of which demanded an answer, ‘Yes’, or ‘No’, or ‘Unclear’ or ‘Not applicable’. CASP checklist for qualitative studies contained 10 questions were each required an answer, ‘Yes’, or ‘Cannot tell’ or ‘No’. A positive (yes) answer to the first two screening questions with the CASP checklist, signify that the research question matched the aim of the review, and the methodology adapted from the article being screened were appropriate in addressing the purpose of the research. An overview of the quality assessment is shown in Table 2 and Table3.

Table 2: Critical appraisal results of qualitative studies using CASP checklist (n = 8) (53)

Criteria	References							
	Småland et al. (2011)	Akhavan S. (2012)	Gele et al. (2015)	Lindkvist et al. (2015)	Larsson et al. (2016)	Hultsjö et al. (2009)	Hakonsen et al. (2014)	Czapka et al. (2016)
1. Was there a clear statement of the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y
2. Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	Y
3. Was the research design appropriate to address the aim of the research?	N	N	Y	Y	CT	Y	Y	Y
4. Was the recruitment strategy appropriate to the aims of the research?	Y	Y	Y	N	N	Y	N	Y
5. Was the data collected in a way that addressed the research issue?	Y	Y	CT	CT	CT	CT	Y	CT
6. Has the relationship between researcher and participants been adequately considered?	Y	Y	N	Y	CT	N	N	N
7. Have ethnic issues ben taken into consideration?	CT	Y	Y	Y	Y	Y	Y	N
8. Was the data analysis sufficiently rigorous?	CT	Y	Y	CT	CT	Y	Y	CT
9. Is there a clear statement of findings?	Y	CT	Y	Y	Y	Y	Y	Y
10. How valuable is the research?	Y	Y	Y	Y	Y	Y	Y	Y
Total 0 – 10 Y	7	8	8	8	5	8	8	6
Appraisal score	M	H	H	H	M	H	H	M

Y = Yes, CT = Cannot tell, N = No L = Low M = Medium H = High

Most of the articles (5 studies) were evaluated as of high quality and 3 studies were evaluated as having medium quality.

Table 3: Critical appraisal results using JBI Analytical Cross-Sectional Studies (n = 6) (52)

Criteria	References					
	Kalengayi et al. (2012)	Hakonsen et al. (2012)	Cantarero-Arévalo et al. (2013)	Stevnsborg et al. (2016)	Rund et al. (2017)	Nielsen et al. (2012)
1. Were the criteria for inclusion in the sample clearly defined?	N	N	Y	N	Y	N
2. Were the study subjects and the setting described in detail?	Y	Y	Y	Y	Y	Y
3. Was the exposure measured in a valid and reliable way?	Y	Y	Y	Y	Y	Y
4. Were objective, standard criteria used for measurement of the condition?	Y	Y	Y	Y	Y	Y
5. Were confounding factors identified?	N	Y	U	U	U	U
6. Were strategies to deal with confounding factors stated?	U	U	Y	Y	Y	U
7. Were the outcomes measured in a valid and reliable way?	Y	Y	Y	Y	Y	Y
8. Was appropriate statistical analysis used?	Y	Y	Y	Y	Y	Y
Total 0-8 Y	5	6	7	6	7	5
Appraisal score	Low	Medium	High	Medium	High	Low

Y = Yes, U = Unclear,

N = No, NA = Not Applicable

Of the six quantitative studies evaluated, two of the articles were evaluated as of high quality as the score 7 “Yes”, another two articles were evaluated as medium quality as they scored 6 “Yes” and the last two papers were evaluated as of low quality as they scored 5 “Yes”. Considering the purpose of scoping review, which is to map all available evidences in a field, all six quantitative studies were included in this review, notwithstanding the quality of the studies.

2.4.3 Stage 4: Charting the data

This stage involves incorporating a numerical summary and qualitative thematic analysis with charting key component themes and information from the selected literature (44). Several readings and observations were required with extensive consultation combined with literature support. This is a process where an individual technique is applied to primary reports and research materials to obtain meaningful data to answer the research questions. The method involved the synthesises and interpretation of qualitative data by sifting, charting and sorting. This was done in accordance with the material content, themes and areas of application (54). A descriptive and analytical framework was applied to primary data consisting of research articles.

A data charting form developed was pilot-tested on three articles to test the data charting form and to ensure consistency. This process was iterative involving continuous updating. The nature and breadth of data to be extracted was resolved through a discussion between the author and the external reviewer (K. A.) in accordance with the purpose the study. Two meetings were held at different intervals after reading through the articles independently, and a final charting form was prepared with the aim of obtaining an overview of the data on each study. The author charted the data from the studies included, which was then cross-checked by the external reviewer (K.A.). The primary data were classified into different areas based on findings during the process.

An excel spreadsheet consisting of data charting form was developed with agreed components (47). A set of the following information was charted from each article included in the review:

- Author(s), year of publication, country of study.
- Objectives and aims of each study or presentation.
- The study type methodology and design.
- Study population and participants size.
- Access barriers and indicators.
- Major results and findings.

The charting form was continually updated as familiarity with the studies, and the charting form grew to ensure the extraction of all relevant results.

2.4.4 Stage 5: Collating, Summarizing and reporting the Results

Scoping reviews can identify the implications of the study findings for policy, practice or research. One advantage of scoping reviews is that all relevant articles included in the study are synthesised notwithstanding results from critical appraisal which could have reduced other contributing articles to the final themes.

This scoping study considered all the findings from every available source to answer the research question. Using the charts from stage 4, the author categorised and display concepts or themes reflecting barriers that shape immigrants access to healthcare services and the relationships between the studies in a grid, see Table 6. for more details.

A narrative synthesis of results of the studies reviewed was presented using themes identified from the articles. All articles provided multiple themes reflecting impediments to healthcare services; and were consequently categorised under different concepts. Attention was given to the primary numeric analysis of the extent, nature and distribution of each study included in the review. A table for mapping was produced with every article related to the charted information highlighted, see Table 4 for more details.

CHAPTER 3

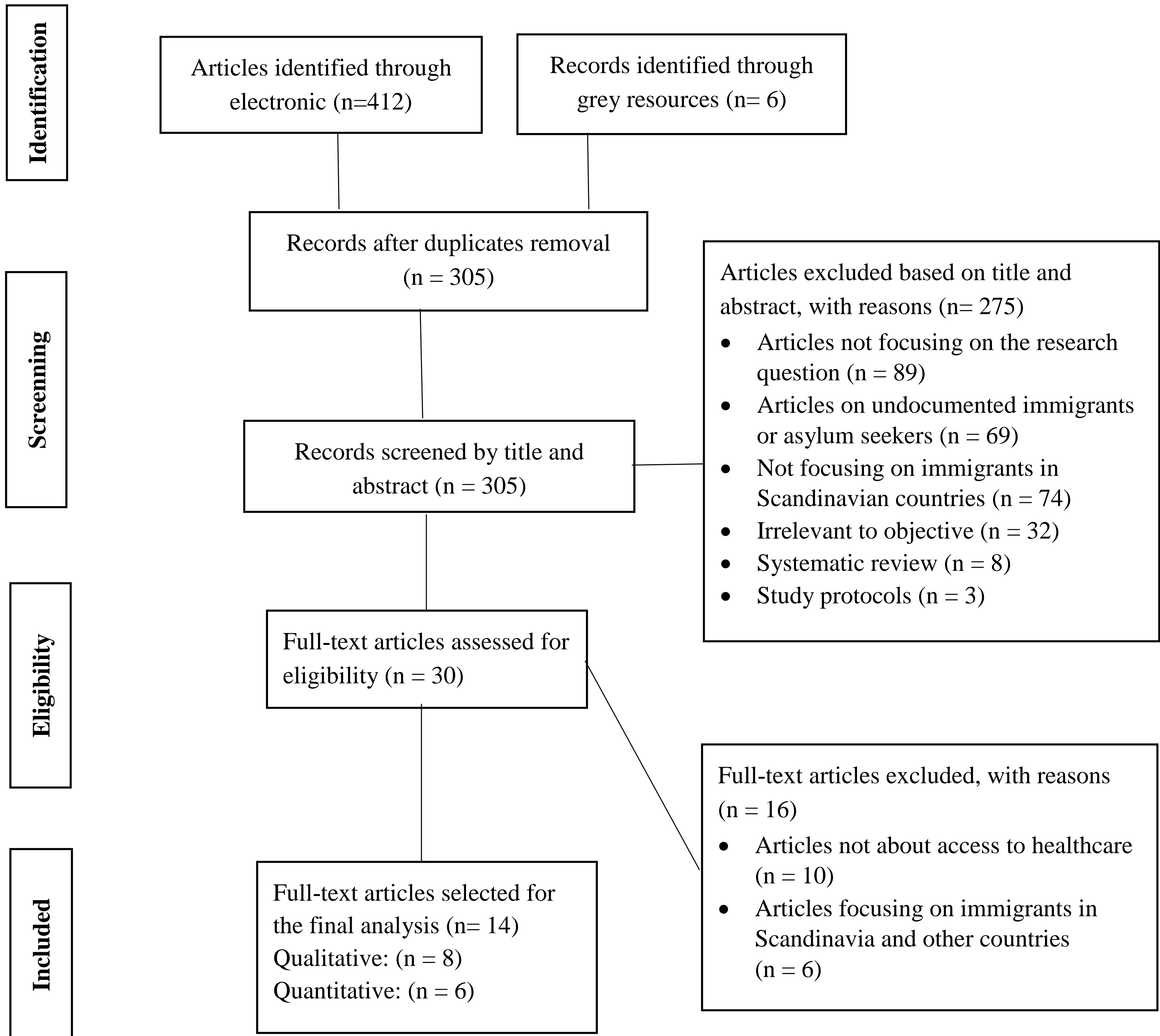
This chapter presents the results and is split into different sections. Section 3.1 provides an overview of the literature identified through screening of all sources and the studies considered relevant for the topic being examined. Section 3.2 provides the demographics and summary of the type of studies included in this review. Section 3.3 presents the thematic analysis of the results. A narrative presentation of the results is provided in section 3.3.1 to 3.3.6 under each theme identified from the studies reviewed.

3 Results

3.1 Literature overview

A total of 418 potentially relevant peer-reviewed articles and grey literature were identified through initial searches (Medline 24, PubMed 162, CINAHL 15, PsycINFO 18 and EMBASE 192; and 6 Google, greylit.org, WHO websites and Google Scholar), of which 108 records were duplicates were removed. Additionally, 275 papers were excluded from the screening based on title and abstract and 30 full-text articles were identified and assessed for eligibility. Finally, 14 studies of which 57% (8/14) were qualitative studies and about 43% (6/14) quantitative studies were selected for the synthesis as demonstrated in Fig. 1. Several grey literatures were identified, but they did not meet the inclusion criteria.

Figure 1: Prisma flow diagram of study review process (55)



3.2 Study type and overview of demographics

The 14 articles included in the final synthesis were stand-alone study projects. 21% (3 out of 14) of the studies were conducted on the views and experiences of healthcare providers (Doctors, midwives or superintendents and pharmacists) (19, 37, 56); 7% (1 out of 14) of the studies focused on the entire population of children (30). One of the studies, 7% (1/14) was conducted on immigrant women from Somali (38), 14% (2 out of 14) of the reviewed articles targeted migrants from the same country: one focused on migrants from Poland and the other first-generation Pakistani immigrants (57, 58). Another two papers, 14% (2/14) targeted migrants from some specific countries: one targeted migrants from Ethiopia and Eritrea and the other article focused on migrants from the former Yugoslavia, Iraq, Iran, Lebanon, Turkey, Somalia, Pakistan; and Turkish and Pakistani descendants (16, 59). The remaining articles, about 36% (5 out of 14) focused on immigrants generally (5, 31, 48, 60, 61) (Table 5). Most of the studies included in this synthesis, 64% (n = 9) focused on barriers experienced by men and women; 7% (n = 1) focused on barriers faced by women and 7% (n =1) children. 21% (n = 3) presented barriers from healthcare providers' (doctors, midwives or the superintendents and pharmacists) perspective and experiences in providing healthcare services to immigrants. Majority of the studies, about 43% (n = 6) were carried out in Norway, followed by about 36% (n = 5) in Sweden and 21% (n = 3) in Denmark (Table 4).

Of the eight qualitative articles included in the final synthesis, five studies were of high quality, and three were of medium quality, while two out of the six quantitative studies included in the review were of high quality, two were of medium quality, and the remaining two were of low quality. None of the articles were excluded following this evaluation as the all the 14 articles reviewed were judged to contribute towards the aim of this study. Details of the quality assessment are shown in Table 2 and Table3.

Table 4: Descriptive overview of studies included (N = 14)

Author/ year/ Country	Objectives	Study designs/	Participants/ sample size	Access barriers indicators	Major findings
1. Småland et al. 2011, (5) Norway	To explore determinants of migrant compliance with the RGP scheme and obstacles that migrants may experience.	Qualitative/ Semi-structure interview	Leaders of migrant organizations, (n = 13)	Doctor-patient communication patterns, language and cultural differences.	Immigrant's integration into the RGP scheme depends on their country of origin, the reason for migration, intention to and length of stay in Norway, language skills and health literacy. Barriers to accessing the RGP scheme included language and cultural differences, physician-patient interaction pattern and conflicting ideas about the role of the doctor.
2. Akhavan S. 2012, (19) Sweden	To explore the views of midwives on the factors that contribute to health care inequality among immigrants.	Qualitative/ Semi-structure interview	Native Swedes midwives or superintendents age 35 – 57 (n = 10)	Cultural differences, language, communication.	Midwives believe inequality in health care among immigrants could be due to language barriers, miscommunication due to few meeting times, cultural differences and practices, limited patient-caregiver trust and difficulties when seeking and receiving health care.
3. Gele et al., 2015, **(38)** Norway	To explore women's knowledge of diabetes, their access to preventive health facilities, and factors impeding their reception of preventive health programs targeted	Qualitative Multi-method	Somali women (n = 30)	Culture, and poor access to health information	Though the Somali immigrant women in the study had a good knowledge of diabetes, they did not change their lifestyle, due to lack of access to tailored physical activity services, health information on diet and poor access to health information.

for the prevention of type 2 diabetes.

Table 4 continued

Author/ year/ Country	Objectives	Study designs	Participants/ sample size	Access barriers indicators	Major findings
4. Lindkvist et al., 2015, **(59)** Sweden	To explore and improve understanding of barriers to HIV testing in a migrated population from Ethiopia and Eritrea in Stockholm.	Qualitative/ Semi-structure interview	Immigrants from Ethiopia and Eritrea Aged 30 – 59 years (n = 29)	Culture, language problems, communication, fear of prejudices, and distrust of the Swedish health system.	Fogging of the HIV issues - barriers to HIV testing: Denial and fear of knowing own HIV status, social isolation and exclusion, the belief that treatment did not help.
5. Larsson et al., 2016, **(56)** Sweden	To explore health care providers' experiences of providing care to immigrant women seeking abortion care.	Qualitative/ Interview	Midwives and doctors, all women (n = 13)	Language limited knowledge, culture and health care structure.	Health care providers are reluctant to acknowledge specific needs among immigrant women; they Strive to provide contraceptive counselling to immigrant women, and they are faced with organisational barriers hindering patient-centred abortion care to immigrant women.
6. Hultsjö et al., 2009, **(60)** Sweden	To describe how foreign-born and Swedish born families living in Sweden perceive psychosis care.	Qualitative/ Explorative with a phenomeno	15 Swedish-born and 11 foreign-born, (28–69 years) (n = 26)	Communication barriers, and differential treatments by healthcare providers.	Access to care and support and knowledge about psychosis were considered necessary as they decrease the level of stress and counteract

		graphic approach			prejudiced attitudes to psychosis in the family and the community.

Table 4 continued

Author/ year/ Country	Objectives	Study designs	Participants/ sample size	Access barriers indicators	Major findings
7. Hakonsen et al., 2014, **(37)** Norway	To identify the cultural barriers encountered by Norwegian community pharmacists in providing service to non-Western immigrant patients and to outline how they are being addressed.	Qualitative/ Focus groups	Ethnic Norwegian pharmacists Age: 25 – 66 years, (n = 19)	Language and cultural barriers,	The pharmacists had challenges in providing adequate service to immigrant patients. Language and cultural barriers affected what the patients got out of the available information, the kind of and how much information was provided. Although immigrant patients needed drug counselling, there were significant disparities in how much effort was exerted to provide this service. Cultural barriers were linked to differences in body language and clothing which the pharmacists thought distracted the communication.
8. Czapka et al., 2016, **(57)** Norway	To explore barriers to and facilitators of Polish migrants' access to Norwegian health care services.	Qualitative/ Interview	Polish migrants in Oslo (n = 19)	Language, communication, knowledge of the health system. Health information and	Insufficient language skills, communication problems and lack of knowledge about navigating the health care system were barriers often experienced and mostly mentioned by the migrants. The organisation of the healthcare

				healthcare personnel's attitude.	system, perceptions of doctors' skills and practices, and attitudes among health personnel were also viewed as barriers.

Table 4 continued

Author/ year/ Country	Objectives	Study designs	Participants/ sample size	Access barriers indicators	Major findings
9. Kalengayi et al., 2012, **(31)** Sweden	To investigate factors that might be limiting immigrants' access to HIV/AIDS care.	Quantitative Survey	Immigrant from two Swedish language schools in Northern Sweden (n = 268)	Fear of deportation, lack of access to available information, stigmatisation, low education, and lack of tailored services.	37% reported reluctance to healthcare if they had HIV/AIDS. Fear of deportation was the most important determinant of reluctance to seek care.
10. Håkonsen et al., 2012, **(58)** Norway	To explore medicine, use among first-generation immigrants from Pakistan who had been residing in Norway 10 years or more, with emphasis on cultural influences, language proficiency, and sociodemographic variables.	Quantitative Interview	First-generation Pakistani immigrants, aged 40 – 82 years (N = 82)	Communication problems, language skills, culture, low education level.	15% of the participants occasionally used drugs acquired from Pakistan. 51% lacked essential knowledge of their drug therapy; 93% believed it was necessary to take drugs every day. About 50% of the subjects altered their drug intake during Ramadan. More women reported symptoms, frequent visits to doctors, and communication problems in the pharmacies.

11. Cantarero-Arévalo et al., 2013, **(30)** Denmark	To analyse whether there are inequalities in asthma treatment by country of birth and ancestry among children residing in Denmark and whether this potential association may vary between different household income groups.	Quantitative Cross-sectional	The entire population of children aged 0 to 17 years in 2008 (n =1 209 091)	Unfamiliarity with the healthcare system	Immigrant children had the lowest probability of redeeming prescription for asthma, both relief and prevention medication compared to ethnic Danes.
12. Stevnsborg et al, 2016, **(61)** Denmark	To conduct a nationwide registry-based study to determine whether inequality exists regarding access to anti-dementia treatment and care between immigrant and Danish-born patients with dementia.	Quantitative Cross-sectional	Native Danes, Western and non-Western immigrants' patients with dementia age 60≥ years in Denmark in 2012 (n = 34,877)	Linguistic differences, unfamiliarity with the healthcare system, and communication difficulties.	Dementia patients with immigrant background had a lower likelihood or receiving anti-dementia medication compared to Danish-born. Non-Western immigrants were less likely to live in a nursing home.
13. Rund et al., 2017, **(48)** Norway	To explore reasons for attending a general emergency outpatient clinic versus a regular general practitioner (RGP).	Quantitative Cross-sectional	457 Immigrants and 565 native Norwegians (n = 1022)	Lack of access to RGP, lack of affiliation with the RGP scheme, language.	Immigrants were more likely to contact their RGP before attending the emergency outpatient clinic compared with native Norwegians. The most frequent reason for visiting the emergency clinic was difficulty making an immediate appointment with their RGP. A common reason for not contacting an RGP among 21% of native Norwegians was lack of access; they claimed

					their Registered General Practitioner was in a district/municipality other were they lived, and 31% of the migrants reported a lack of affiliation with the RGP scheme.
14. Nielsen et al., 2012, **(16)** Denmark	To investigate whether differences in healthcare utilisation in immigrants, their descendants, and ethnic Danes could be explained by health status, socioeconomic factors, and integration.	Quantitative Cross-sectional	Immigrants from the former Yugoslavia, Iraq, Iran, Lebanon, Turkey, Somalia, Pakistan; and Turkish and Pakistani descendants, and ethnic Danes; Aged 18−66, (n = 4952)	Culture, and communication.	Immigrants and their descendants had increased use of ER and less frequent contact with the dentist. Most immigrant and descendant groups had increased use of services compared to ethnic Danes. Socioeconomic factors and integration had no systematic effect on the use of the different groups.

3.3 Thematic analysis of the results

A thematic method of analysis of the results was applied because it allows for flexibility in the choice of framework, and provides an inductive and a systematic approach for the summary of main features in the data. An inductive and a priori approach was applied to identify the themes for the final synthesis. This means that the themes identified were from the data collected and the author's prior theoretical knowledge of barriers to accessing healthcare services. A priori themes emerge from professional definitions of barriers to accessing healthcare found in literature, theoretical orientations, common-sense constructs, researcher's values and personal experiences (62). Thematic analysis is also systematic because it involves making systematic comparisons across the data collected by searching for differences and similarities in the data (62). The following categories of barriers were identified within the papers and presented in Table 5: (i) Communication and language, (ii) culture, (iii) healthcare provider's attitude or response (doctors, midwives or superintendents and pharmacists) attitude, (iv) knowledge about health system structure, (v) stigmatisation, fear of prejudice and deportation and (vi) and level of education.

The themes were identified by reading and rereading the articles and marking the text up with different coloured pens and underlining key phrases and reoccurring topics. Concepts identified from the articles were inspired by other empirical studies but were modified by the categories of themes that emerge from the articles reviewed. Themes identified from the articles were compared for similarities and differences, and those found appropriate to answer the question raised by the review were listed in a grid showing the themes within each study and the relationships between them.

The majority of the studies reviewed, 64% cited language, 57% communication and 57% cultural barriers to accessing healthcare services by immigrants in Scandinavia. About 36% indicated insufficient knowledge about the health system, 14% reported healthcare providers attitudes; 14% mentioned stigmatisation, fear of prejudice and deportation, and another 14% cited the level of education as an impediment to accessing care and services.

Communication and language barriers were interrelated as six out of eight studies that reported communication barriers also cited language barriers. However, four of the eight article that identified cultural barriers reported communication and language barriers as well.

Communication and language barriers as reported by healthcare professionals and immigrants represent a source of concern as they were both are unsure if the other understands the information given and whether the need for healthcare is satisfied (63).

Table 5: Grid displaying key themes within each article and the relationships between the studies

	Concepts					
References	Communication and Language	Culture	Healthcare providers' attitudes or response	Knowledge of healthcare system	Stigmatization/ fear of prejudice/ deportation	Level of education
1. Småland et al. 2011, (5) Norway	X	X				
2. Akhavan S. 2012, (19) Sweden	X	X				
3. Gele et al., 2015, (38) Norway		X				
4. Lindkvist et al., 2015, (59) Sweden	X	X			X	
5. Larsson et al., 2016, (56)Sweden	X	X		X		
6. Hultsjö et al., 2009, (60) Sweden	X		X			

7. Hakonsen et al., 2014, (37) Norway	X	X				
8. Czapka et al., 2016, (57) Norway	X		X	X		
9. Kalengayi et al., 2012, (64) Sweden					X	X
10. Hakonsen et al., 2012, (58) Norway	X	X				X
11. Cantarero-Arévalo et al., 2013, (30) Denmark				X		
12. Stevnsborg et al., 2016, (61) Denmark	X			X		
13. Rund et al., 2017, (48) Norway	X			X		
14. Nielsen et al., 2012, (16) Denmark	X	X				
Total	11	8	2	5	2	2

3.3.1 Communication and language

Communication problems in a healthcare setting were found to contribute to misunderstanding and create obstacles to access to healthcare services and health inequalities (5, 19). Studies in Scandinavia have found communication problems to be a source of barrier in the doctor-patient relationship (5, 19, 56, 59).

Migrants having insufficient language skills are more reluctant to visit a doctor. Male-partners of migrant women having language problems often served as interpreters and in some cases, take charge of the communications between healthcare providers on behalf of the female migrants. The involvement or interference of male migrants in the consultation between healthcare providers and female migrants creates uncertainty as to what the female migrant understood of the information received (19, 37). Participants in a study by Gele et al. (38), preferred receiving information in their language (Somali), through visual learning inform of pictures and through words of mouth.

Polish migrants in Norway prefer to use the Polish health services due to insurmountable language barriers, resulting in a misunderstanding of the doctor-patient relationship and their refusal to visit doctors in Norway (57). Furthermore, the use of professional interpreters may not guarantee an excellent communication between migrants and healthcare providers but may lead to misuse of translator and communication barrier if the interpreter does not speak the right dialect (37, 59, 60). Misinterpretation of the needs of migrants or the information from the doctor to the migrant patient may lead to health inequalities and lack of access to care (59).

Communication is not exclusively verbal but also non-verbal (body language, clothing, food facial expression, gestures, eye contact and tone of voice) and primarily influenced by different cultural backgrounds, which may hamper access to adequate health information; and access to care and services. Traditional Muslim garments (burqa) were found to be barriers to communication since the garments cover the face making it difficult to understand their body language (37, 59).

Lack of language skills was reported as a significant barrier to counselling of migrant patients and access to information (5, 37, 57, 58). According to Goth and Berg (5), doctor-patient communications involving immigrants was significantly hampered by the lack of common skills in any language and health literacy. Language problems were shown to impede understanding of the health system and confidence in the general practitioner (GP), leading to frequent utilisation of emergency care. Language barrier made communication between care

providers and migrant patients, especially those who are more in need of healthcare services problematic (57).

To bridge communication gap and solve language problems, both healthcare professionals and immigrant patients employed the services of interpreters (37). Reports showed that immigrants and healthcare professionals occasionally, employ the assistance of family members (even children) or friends of immigrant patients to translate in the case where the patient lacks the necessary language skill (37, 57). Three studies reported that the use of non-professional interpreters, especially children to interpret, is a source of insecurities for care providers (37, 57, 58). According to Gele et al. (38), the use of unskilled interpreters or children as translators because of language problems made healthcare providers to doubt their abilities to deliver information correctly. Furthermore, the utilisation of children as interpreters led to the provision of basic information to immigrant patients to spare the children of sensitive issues. On occasion, children were sent by themselves to claim prescriptions for their parents(37). Håkonsen et al. (37), reported that pharmacists were asked to give drug counselling via the telephone, but the exercise was unsuccessful since the migrant patients were not always able to speak Norwegian fluently or in a comprehensible way.
According to Goth and Berg (5), limited language abilities meant that some migrant patients need more time to describe their problems. Language barriers increase with the use of telephone interpreters because it makes it more challenging for immigrant patients to explain their symptoms and health status, which often result in the frequent use of emergency services (5). Communication problems involving the use of an interpreter require additional time and resources. Goth and Berg (5), reported that the utilisation of language interpreters from the same community as the immigrant patient might also create insecurities regarding the professional conduct of the translator for maintaining confidentiality.

3.3.2 Cultural barriers

This scoping review identified several aspects of cultural barriers. One of the most evident cultural barriers reported by three studies was the patriarchal role of the Muslim male and religious beliefs (19, 37, 56). The patriarchal culture and religious beliefs often lead to cultural collisions between healthcare professionals and migrants (19). The dissimilarities in

cultural beliefs, expectation and behaviours may result in miscommunication and misunderstanding (19). Cultural diversities, religious beliefs and norms, and language barriers affect access to available information, the type and quality of information given to immigrants, their understanding of the information received and their decisions to accept and adhere to some types of treatment and medications (19, 37).
Cultural differences and the patriarchal role of male Muslim migrant over their female-partners results in healthcare professionals' reluctance to probe migrant patients for more information on their illnesses, diseases and symptoms. Instead, they are offered services of lesser qualities which meant that certain conditions such as mental health disorders and others caused probably by immigration process might not be uncovered (19, 37).
Norwegian community pharmacists reported that the detraction in communication due to diversity in body language and clothing of non-Western migrant were related to cultural barriers (37). As reported by Håkonsen et al.(37) and Gele et al. (38), the absence of culturally sensitive healthcare professionals and structures among others impedes access to healthcare services and increases health disparities among migrants. Akhavan S. (19), highlighted the need for culturally sensitive healthcare professionals as resources for the provision of culturally sensitive healthcare services. The same author, further stated that the provision and promotion of culturally appropriate healthcare services require the employment of several bilingual and bicultural healthcare providers (19).
According to Gele et al. (38), migrant women from Somali reported that health information without a culturally sensitive structure might not be sufficient for the prevention of diseases. Furthermore, most female migrants of non-western origin will not consent to a male-assigned GP for examination, or even be alone with a male GP in a closed room. At the same time, the patient is often not aware of the possibility of changing assigned GPs and requesting a female doctor's (5).

3.3.3 Healthcare providers' attitude or response

In a study by Håkonsen et al., pharmacists stated that they often intentionally provide migrants sparse drug information, informing them of the basic, even when they were aware of the migrants' lack of necessary drug information. The pharmacists provided sparse information such as (when and how to use the drugs) so that they can easily disclaim responsibility, while they counted on the doctors to provide the necessary information on side

effects (37). The same study reported that healthcare providers reluctance to deliver equitable healthcare services to immigrants was due to fear of being accused of racism and the possibility to easily disclaim responsibility, should they make cultural mistakes in their interactions with them (37). Language barriers and lack of medical knowledge led to mistrust (19). Non-western migrants experienced the attitudes and abilities of the doctors in the host country as confusing and different from their country of origin (5).

Insufficient language skills often result in obstacles accessing written information provided in any of the Scandinavian languages. Migrant reported difficulties obtaining and understanding available information on health-related websites when they were referred to the internet by their GPs due to lack of language proficiency and computer literacy (57). Participants in a study by Gele et al. (38), preferred to receive health information in their language and orally.

3.3.4 Knowledge about health system structure

Migrants to Scandinavian countries are offered language courses after they have established their stay in the host country, but they are not provided with a program where they may acquire knowledge about “Scandinavian” health systems (57, 59). According to Czapka and Sagbakken (57), immigrants’ lack of knowledge about Norwegian health system leads to distrust in the services and barriers to accessing healthcare services.

Swedish healthcare system utilises an automated telephone system connected to an answering machine which provides step-by-step instruction requiring fluency in the Swedish language from migrants to access the Swedish health system (59). As discussed by Cantarero-Arévalo et al. (30), unfamiliarity with the Danish healthcare system and non-structural impediments to health care services leads to lesser contacts with care professionals. Furthermore, immigrants’ children had a lower likelihood of redeeming a prescription for asthma medication compared to the native population because their parents were unfamiliar with the healthcare systems (30). Participants in a study by Lindkvist et al. (59), pointed out that difficulties in accessing Swedish healthcare system lead them to seek medical care from drop-in clinics or emergency services. Language problems and unfamiliarity with the health system structure may create difficulties navigating the system, leading to dissatisfaction and resulting in lack of compliance with treatment (61).

3.3.5 Stigmatisation, fear of prejudice and deportation

One study mentioned stigmatising attitude towards migrants in general and individuals living with HIV/AIDS, and the association between fear of deportation and reluctance to seek care by some migrants, despite their legal residency in the host country. According to Lindkvist et al. (59), immigrants living with HIV/AIDS may be in fear of stigmatisation and prejudice from their community and the host country, should their HIV status be disclosed. Fear of deportation and a subsequent disclosure of HIV status may hinder access to healthcare services (31, 59).

3.3.6 Level of education

Based on the experiences of some participants in a study by Akhavan S. (19), low education level was thought to halt immigrant women's utilisation of healthcare services. Pharmacists who occasionally suspect immigrant patients to be illiterate, sometimes issue written information or point them to the written instructions on the package without knowing how much of the information will be understood (37). Kalengayi et al.(31), reported that low-educated immigrants from the Middle East were thought to have reduced understanding or lack of access to available information. The authors further indicated that health promotion campaigns do not adequately focus on immigrants from the Middle East both in their countries of origin and host country (31).

CHAPTER 4

This chapter presents the discussion of the results, limitations and strengths of this review and implications for public health.

4 Discussion

The findings in this review highlight barriers in relation to accessing healthcare services by immigrants in Scandinavian countries. Although the immigrants had legal residence in the host country, which entitled them to equal access to healthcare services as the native population, various factors made access to services a challenge. These are communication and language, culture, healthcare providers' attitudes, knowledge about health system structure, stigmatisation and fear of deportation and level of education. Based on the studies reviewed, the barriers experienced by immigrants when accessing healthcare services seemed to be interrelated; an impediment in a healthcare sector affected other sectors.

4.1 Communication and language barriers

Communication barriers in a patient-doctor relationship are likely to affect the interactions for example between pharmacists and the immigrant because the pharmacists expect the doctors to provide the information they have not delivered to the patients, while the doctor expects the pharmacists to give adequate information on the medication they issue patients. Patients who had insufficient language skills had problems communicating with care providers, difficulties understanding the healthcare system and lacked confidence in their GP.

Of the six themes identified, communication and language and cultural barriers were reported in almost all the studies. Of every 8 article that stated communication barriers, five also reported language barriers, and of every article that mentioned language and communication barriers, four also reported cultural barriers. In the first place, language, communication and cultural factors were found to limit and determine the type of drug information healthcare professionals provided immigrant patients, as they relied on other healthcare professionals to give the rest of the information. Hence, the realisation that other health professionals will not necessarily resolve the challenges and experience of barriers in another group of health providers encounter in the provision of services to immigrant patients is important as they may all be facing similar challenges and barriers (37). Language, communication and cultural

barriers hampered female immigrants access to one-on-one consultation with the doctors as their male counterparts often interfere or take charge of the conversation. Consequently, healthcare professionals were unsure if the female patients understood what was being said under the consultation or counselling as they had to refer to the male companion (spouse). The interaction between healthcare staffs and patients is essential for the care provider to uncover symptoms, health status and make proper diagnoses, and to plan appropriate treatments (65). Barriers to the communication may result in frustration both for the healthcare provider and patient because it makes counselling or consultation challenging and time-consuming and requires extra resources. Language proficiency is essential to accessing healthcare services in Scandinavian countries. Access to healthcare systems in Scandinavia, besides emergency cases, requires planning and language proficiency from migrants. Making an appointment with a GP involves fluency in one of the Scandinavian languages. In Norway, patients in need of a meeting with their GP should be able to communicate their need, in Norwegian via a telephone call or a text message. Lack of language skills and inability to communicate in the Scandinavian languages makes navigating and familiarity with the health systems challenging. Unfamiliarity with the Scandinavian healthcare “systems” may result in dissatisfaction and lack of adherence to treatments. This may further complicate the conditions of patients with, for example, diabetes a condition that may require a close follow-up by the patients and healthcare professionals.

4.2 Cultural barriers and sensitivity

Cultural diversities and healthcare providers’ response to the challenges these differences posed, led to barriers to accessing healthcare services. The reduced availability of a culturally sensitive healthcare professionals and systems, and language and communication barriers are likely to lead immigrants to rely more on their family, community, network and friends for information, support and advice. However, the information and advice from their family, community, network and friends may not be accurate, and these persons may not respect confidentiality. The lack of culturally sensitive professionals, system and services as a barrier to accessing healthcare services have also been found in studies conducted outside Scandinavia (9, 66). Ahmed et al. (9), also reported similar findings from studies done in the United States of America (USA), Canada as well as Australia. Evidently, the provision and

promotion of culturally relevant healthcare services require the inclusion of bicultural skill training into the regular practice for healthcare providers. This may increase healthcare professionals' knowledge about the difficulties and better equip them for their practice. Non-western female immigrants mentioned their preferences for female GPs and their lack of willingness to be examined by a male gynaecologist due to cultural and religious beliefs. This barrier may be overcome with the provision of information and the possibility to request for a female gynaecologist.

The patriarchal role of the Muslim male and religious beliefs, often lead to cultural collisions between the immigrants and healthcare providers. Healthcare professionals were faced with various challenges in delivering care and services to female migrants due to the patriarchal role of the Muslim male. Male immigrants often interfere or take charge of the consultation and interactions on behalf of the female patients (spouses), indicating that the man oversaw the needs of the patients. The patriarchal role meant that the male immigrant (husband) were given confidential health information on behalf of the patients (spouses) without the certainty that the information provided will be accurately delivered to the patient. Male pharmacists expressed their concern and fear of being misunderstood when in contact with female immigrant patients, and for this reason, they were cautious and reserved when in contact with this group of patients. The role of Muslim male and religious beliefs affected the type of information they were given, and the decisions immigrants made.

A study reported that the traditional Muslim garment (burqa) created barriers in communication as it covered their faces, making it challenging to observe their body language (37). Body language as part of non-verbal communication provides important information during communication, and this can be very important for the doctor-patient communication. The Muslim women wear burqa for religious and cultural reasons, and it may be challenging to do without it. These findings are supported by a previous review by Ahmed et al. (9), on the barriers to access to primary health care by Canadian immigrants.

4.3 Fear of stigmatisation and deportation

The fear of stigmatisation and prejudice by immigrants' own community due to a disease that is culturally stigmatised led to reluctance in seeking care. Furthermore, despite having legal residency in the host country, immigrants were still afraid of being deported should their health status be uncovered; hence they were reluctant to seeking healthcare services.

According to Kalengayi et al., the fear of deportation among legal immigrants is associated with lack of access to or poor understanding of available information and the lack of tailored public health education campaign for low educated immigrants from countries with low prevalence of HIV/Aids (31). Furthermore, based on Australian Migration Act 1958 (67), immigrants with chronic illnesses and disabilities are not able to renew their visa or apply for permanent residency, and they may be deported due to their health status.

4.4 Interpreters and barriers

In the studies reviewed, language and communication barriers were cited both by immigrants and healthcare professional. Language skills posed a significant barrier to accessing healthcare services. Language and communication as discussed by Ahmed et al., has a significant impact on the quality of the interactions between doctors and their patients (63). Due to language and communication barriers, children were sent alone to claim prescriptions for the parents, and pharmacists were asked to provide drug counselling via telephone, but this was unsuccessful as the immigrants were not fluent in Norwegian nor spoke comprehensively to understand what was being said under the counselling. However, to overcome communication and language barriers, healthcare professional and immigrants were reported to employ the services of both skilled and unskilled interpreters, such as family members of the patients, even children to the interpreter to their parents under counselling or consultations with the patients. However, the lack of trust due to fear of family members not respecting confidentiality may cause migrants to hold back on their health status (68). The use of children as interpreters for immigrant during counselling or consultation made it difficult for healthcare providers to ensure that appropriate information is given and at the same time protect the children serving as a translator from sensitive information.

Although the services of professional interpreters were available on some occasions, the immigrants have not always understood their interpretation, and it may lead to miscommunication. Miscommunication resulting from the use of skilled interpreters may be due to several factors including the use of a different dialect, the interpreters may understand the language, but not the right dialects. Use of interpreters, therefore, become barriers to communication rather than bridging the communication gap. The findings in this review are consistent with a review by Ahmed et al. (63), on the experiences of communication barriers between physicians and immigrant patients.

4.5 Level of education and barriers

Level of education was believed to impede female immigrants' utilisation of healthcare services. Immigrants from the Middle East were thought to have a reduce understanding or lack of access to available information due to Low-education among them. However, pharmacists who sometimes suspect immigrant patients or clients to be illiterate, occasionally issue written information or point them to the written instruction on the package with no possibility of knowing if the information is understood. This may lead to misuse of the drugs, which may further complicate the patients' health. Access to an accurate information may guide the patients on why they should comply with their treatments, and how and when to take their drugs. Language problems and unfamiliarity with the health system may create difficulties navigating the system, leading to dissatisfaction and resulting in lack of compliance with treatment.

4.6 Healthcare providers attitudes or response

Healthcare providers' attitudes and behaviour are influenced greatly by professional norms, such as, attitudes, values, meaning, and preferences**,** these are created by professional training, and further shaped by life experiences, and interaction between healthcare professionals and their social environment. Health services for immigrants are dynamic and impacted by care providers' attitudes and immigrants' health need, and influenced by underlying healthcare system (69). A poor provision of competent linguistic services may limit immigrants' ability to communicate comprehensively with healthcare providers and understand the information they are provided. According to Harpelund et al. (65), language barriers can diminish healthcare providers' perception of migrants health problems. Immigrants lacking adequate access to healthcare services due to language and communication barriers tend to utilise emergency services more often than native-born. They use more emergency services as they are usually not required to make an appointment, whereas it may be necessary to explain their health state and need for care before getting an appointment with a GP (70). These findings indicate there are unmet access needs among immigrants in Scandinavia countries. According to Salinero-Fort et al. (36), immigrants lose the health advantage they had upon arrival, and their health deteriorates with the length of stay in the host countries, and due to low-education, poverty and discrimination. Additionally, access barriers heighten the health conditions of immigrants and hinder them from integration, and lack of integration leads to

marginalisation, and marginalisation exacerbates the process of health status, and health conditions heighten marginalisation (71). Hence, immigrants' access needs should be an area of concern to public health professionals because barriers to accessing healthcare services by immigrants impede integration. In contrast, immigrants in good health who have successfully integrated into the new sociocultural context, are more receptive to employment and education, and resultantly are more able to approach the challenges they encounter in the host societies (71). Furthermore, integration is essential for adequate delivery of healthcare services.

The presents review found cultural barriers which include language and communication and unfamiliarity with the healthcare system impeded female immigrants access to healthcare services, and the patriarchal role of Muslim male, limited access to information and determined the kind of decision they made. Furthermore, the experiences of barriers to accessing healthcare services by children were due to their parents' lack of familiarity with the healthcare systems, and as a result, they had a lower likelihood of redeeming medication for the children.

4.7 Methodological considerations

4.7.1 Limitations

The findings in this scoping review should be viewed in consideration of the methodological limitations of the studies reviewed. One of the limitation of this review is the inclusion of studies with low quality, which may lead to questions about the validity and applicability of the findings of this study. However, this has no impact on the reliability of the conclusion of this review. Several studies were excluded from this review as per inclusion criteria. Studies that included asylum seekers and undocumented immigrants were not included in this study, and the exclusion of these articles may have confounded the findings regarding legal immigrants' experiences of barriers to accessing healthcare services. Students and immigrants with temporal residences were not included in this review.

There were only qualitative and quantitative studies in the final synthesis as other papers, reports and commentaries identified were not relevant to the objectives of the review. Only studies published in the English language were considered to avoid the cost and problems of translation, and given that the study is about Scandinavian immigrants, this may have limited

the number of articles that could have been identified. There were over 305 articles considered for this review of which about only 14 were considered as part of the data. Some relevant articles might have been missed as the search for the literature was limited by the English language, and year of publication due to time constraints.

4.7.2 Strengths

One of the strengths of this scoping review was that the articles reviewed was conducted on legal immigrants in Scandinavia countries, nations with similar healthcare systems, thereby overcoming confounding factors that may be associated with different healthcare systems. Secondly, the assessment of the quality of the evidence included in this review, based on refinements of Aksey and O'Malley framework by several authors, makes the interpretation and application of the findings into policy and practice possible. Furthermore, an extensive and comprehensive search terms were applied to identify studies that examined the field of immigration, barriers to access and healthcare services. Publication bias was addressed by searching through a wide range of sources. The six thematic components of barriers to accessing healthcare services provided this scoping review with a robust framework for extraction of data and analysis. This review only focused on immigrants in Scandinavia. However, by incorporating the Nordic countries (Denmark, Norway, Sweden, Finland, Iceland and Greenland), into the research and analysis, comparing barriers in the Nordic scenario would have been made possible, which may lead to improved understanding and a better mitigation of the barriers. Finally, this review was conducted by the main author, with the contribution of two external reviewers to increase credibility in the research process and results.

4.8 Implication for public health

Based on the findings from this review, barriers to accessing healthcare services and the consequences thereof, should be considered a public health issue. Immigrants with health problems that could have been treated do not receive the necessary treatments and preventable diseases such as HIV/Aid may be transmitted to other members of the society due to barriers to accessing healthcare services. It is the responsibility of the public health officials to make sure that adequate access to information is provided in different languages and in the manner

immigrant patients can understand. Health conditions and culturally discriminating diseases that leads to fear of deportation and reluctance to seek healthcare services among immigrants could manage by the provision of awareness campaigns that can motivate immigrants to seek healthcare services in the early stages of their conditions. According to Chandra et al. (72), awareness campaign increases the awareness of people on the issues they were being made aware of. The treatment of the few with ill health should be considered equally crucial as the prevention of the spread of diseases by them to more individuals in the societies. Immigrants with health problems such as diabetes, cancer, hypertension and cardiovascular diseases create more demand on the healthcare systems and the delay to prevent and or treat these conditions due to barriers to accessing healthcare services increases the need for healthcare and the deterioration of the health of immigrants may be accelerated. However, the results of this study should be interpreted with care due to the quality of some of the studies included in the review.

CHAPTER 5

This section covers the conclusion and recommendations based on findings and gaps identified, and the resultant discussion.

5 Conclusion

This review identified gaps and mapped several barriers that hampered access to healthcare services in the articles included in the study. The barriers that were identified were listed in a grid (Table 5) and the results were presented under each theme identified and subsequently discussed. This study has demonstrated that there are several barriers to accessing healthcare services by immigrants in Scandinavian countries. Additionally, the barriers are interrelated and affects immigrants in different levels of healthcare systems (primary and secondary health systems) and in different ways. Immigrants who are unable to communicate or understand any of the Scandinavian languages are faced with challenges understanding the information that is given to them by a healthcare professional. Access barriers as identified by this study also affect healthcare providers attitude or response in their delivery of services to immigrant patients. Healthcare professionals responded to the challenges they encounter in the delivery of services to immigrant patients by providing them with sparse information so that they can quickly disclaim responsibility should a need arise because they felt insecure in their abilities to deliver information and services adequately. Children and female immigrants faced different types of challenges. Female immigrants experienced cultural barriers which included communication and language barriers; these barriers were further exacerbated by the patriarchal role of the Muslim male and religious beliefs. Experiences of barriers to accessing healthcare services by children were because their parents were unfamiliar with the health system.

A major finding from this review was that cultural barriers, which include communication and language was an impediment to accessing healthcare services, and the use of interpreters often led to misunderstanding rather than bridge the communication gaps.

This review underspin the need to incorporate cultural competency into healthcare sector and health professionals' practice to mitigate barriers to accessing healthcare services by immigrants in Scandinavia.

5.1 Recommendations

In light of the findings presented in this scoping review, and the resultant discussion, the following recommendations are suggested for policy, practice and future research:

- Immigrants with low-education and those who are not able to read should be provided with visual information and information in their language.
- The provision of more awareness campaigns on health issues that leads to discrimination, fear of deportation and reluctance to seek healthcare services among immigrants.
- Immigrants should be supported and encouraged to pursue health professional education to reduce the lack of bicultural healthcare staffs in the healthcare sector.
- Further research examining immigrants who gained access to healthcare services notwithstanding barriers, the types of barriers they encountered in their interaction with healthcare professionals and healthcare systems and how to overcome them.

Appendices

Appendix 1: Search strategies for Ovid PsycINFO

POPULATION	**Searches**	**Results**
1. Immigrant	exp Immigration/	19,236
2. Migrant	exp Immigration/ or migrant.mp.	22,913
3. Foreign-born	foreign-born.mp.	1,738
4. Alien	exp Immigration/ or alien.mp.	21,207
5. Emigrant	emigrant.mp.	146
6. Immigrant OR migrant OR foreign-born OR alien OR emigrant	1 or 2 or 3 or 4 or 5	26,059
HEALTHCARE SERVICES		
7. Health care services OR primary healthcare services OR general practitioners OR community services	exp Health Care Services/ or exp Primary Health Care/ or exp General Practitioners/ or exp Community Services	126,361
8. Family doctor	exp Family Physicians/	1,493
9. home care	exp Home Care/	5,794
10. health promotion	exp Health Promotion/	21,433
11. emergency care	exp Emergency Services/ or emergency care.mp.	7,445
12. specialist care	specialist care.mp.	335
13. dental care	exp Oral Health/ or exp Dental Health/ or dental care.mp.	1,630
14. 7- 13/ OR	7 or 8 or 9 or 10 or 11 or 12 or 13	158,123
KEYWORDS FOR BARRIER		
15. barrier*	barrier*.mp.	58,375
16. impediment	Impediment*.mp.	3,243
17. inequalit*	exp Health Disparities/ or inequality.mp.	18,143
18. difficult	Difficult*.mp.	221,977
19. hurdle	Hurdle*.mp.	1,643
20. obstacle	Obstacle*.mp.	17,112
21. obstruction	Obstruction.mp.	1,262
22. issue*	issue*.mp.	375,214

23. challenge*	challenge*.mp.	173,464
24. mistrust	Mistrust.mp.	2,166
25. 15 – 24/ OR	15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24	761,951
KEYWORDS FOR ACCESS		
26. utilization	exp HEALTH CARE UTILIZATION/ or utilization.mp.	38,259
27. usage	Usage.mp.	50,884
28. availability	availability.mp.	33,218
29. accessibility	accessibility.mp.	10,672
30. affordability	affordability.mp.	894
31. acceptability	acceptability.mp.	10,708
32. 26 – 31/ OR	26 or 27 or 28 or 29 or 30 or 31	137,945
COUNTRY		
33. Scandinavia	scandinavia.mp.	704
34. Norway	Norway.mp.	7,682
35. Sweden	sweden.mp.	12,522
36. Denmark	Denmark.mp.	5,366
37. 33 – 36/ OR	33 or 34 or 35 or 36	24,365
38. 6 AND 14 AND 25 AND 32 AND 37		**18**

Appendix 2: Search strategies for CINAHL (EBSCO*host*)

POPULATION		**Results**
1. Immigrant	(MM "Immigrants+") OR (MM "Emigration and Immigration")	7,650
2. Migrant	(MH "Transients and Migrants") OR "migrant"	3,214
3. Foreign-born	"foreign-born"	1,007
4. Alien	"alien"	275
5. Emigrant	(MM "Immigrants+") OR (MM "Emigration and Immigration") OR "emigrant"	7,661
6. Immigrant or migrant or foreign-born or alien or emigrant	S1 OR S2 OR S3 OR S4 OR S5	11,172
HEALTHCARE SERVICES		

7. Primary healthcare services	(MM "Primary Health Care") OR (MH "Home Health Care+") OR (MH "Health Services Needs and Demand+") OR (MH "Emergency Service+") OR (MH "Health Services for the Aged") OR (MH "Health Services Accessibility+") OR (MH "Interpreter Services") OR (MH "Community Health Services+") OR (MH "Nursing Service") OR (MH "Nurse-Midwifery Service") OR (MH "Maternal Health Services+") OR (MH "Health Services+") OR (MM "Community Service")	679,754
8. General practitioner	(MH "Physicians, Family") OR "general practitioner"	11,986
9. Family doctor	"family doctor"	660
10. home care	(MH "Home Health Care+") OR (MH "Nursing Home Patients") OR (MH "Nursing Homes+") OR (MH "Health Care Delivery+") OR (MH "Tertiary Health Care") OR (MH "Secondary Health Care") OR (MH "Nursing Care Delivery Systems+") OR (MH "Health Services Accessibility+") OR (MH "Primary Health Care")	260,012
11. health promotion	(MH "Health Promotion+") OR (MH "Home Health Aides") OR (MH "Community Health Nursing+") OR (MH "Community Health Services+") OR (MH "Dental Health Services+") OR (MH "Maternal Health Services+") OR (MH "Public Health Dentistry+")	299,903
12. emergency care	(MH "Emergency Care+") OR (MH "Emergency Service+") OR (MH "Emergency Medical Services+") OR (MH "Transcultural Care") OR (MH "Transitional Care") OR (MH "Health Care Delivery, Integrated")	86,015
13. specialist care	"specialist care"	476
14. dental care	(MH "Dental Care+")	8,829
15. primary healthcare services or general practitioner or family doctor or home care or health promotion or emergency care or specialist care or dental care	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14	834,493
KEYWORDS FOR BARRIER		
16. barrier*	"barrier*"	43,304
17. impediment	"impediment"	388
18. inequalit*	"inequalit*"	7,455
19. difficult	"difficult"	37,042
20. hurdle	"hurdle"	352
21. obstacle	"obstacle"	1,437
22. obstruction	"obstruction"	11,587

23. issue*	"issue*"	169,757
24. challenge*	"challenge*"	89,897
25. mistrust	"mistrust"	657
26. barrier* OR impediment* OR inequality* OR difficult* OR hurdle OR obstacle OR obstruction OR issue* OR challenge* OR mistrust	S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25	328,705
KEYWORDS FOR ACCESS		
27. utilization	"utilization"	134,104
28. usage	"usage"	8,647
29. availability	"availability"	19,837
30. accessibility	"accessibility" OR (MH "Health Services Accessibility+")	55,310
31. affordability	"affordability"	885
32. acceptability	"acceptability"	5,877
33. utilization OR usage OR availability OR accessibility OR affordability OR acceptability	S27 OR S28 OR S29 OR S30 OR S31 OR S32	209,565
COUNTRIES		
34. Scandinavia	(MH "Scandinavia+")	38,912
35. Norway	(MH "Norway")	7,305
36. Sweden	(MH "Sweden")	17,122
37. Denmark	(MH "Denmark")	7,169
38. Scandinavia or Norway or Sweden or Denmark	S34 OR S35 OR S36 OR S37	38,912
39.	S6 AND S15 AND S26 AND S33 AND S38	**19**

Appendix 3: Search strategy - EMBASE

POPULATION	**Search terms**	**Results**
1. exp immigrant/	immigrant	13430

2. exp migrant/ or migrant.mp.	migrant	34226
3. migrant/	migrant	4055
4. emigrant/	emigrant	192
5. foreign-born.mp.	Foreign-born	3248
6. exp immigrant/ or exp migration/ or exp immigration/	Immigrant, migration, immigration	53588
7. immigrants.mp.	immigrants	16965
8. emigration.mp. or exp migration/	Emigration, migration	45554
9. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8	Emigrant, emigration, foreign-born, immigrant, immigrants, immigration, migrant, migration	77969
HEALTHCARE SERVICES		
10. exp primary health care/	primary healthcare	139577
11. exp secondary health care/	Secondary health care	4558
12. health care quality/ or mental health care/ or mental health/ or mental health service/ or health care/ or health care delivery/	health care, health care delivery, health care quality, mental health, mental health care, mental health service	597135
13. oral health.mp.	oral health	20000
14. exp dental care/ or oral healthcare.mp.	dental care, healthcare, oral	157617
15. exp general practitioner/	general practitioner	82261
16. general practitioner scheme.mp.	General, practitioner, scheme	8
17. family doctor.mp.	Doctor, family	3507
18. elderly care/ or nursing home/	elderly care, nursing home	83588
19. home care/ or community health nursing/	community care, community health nursing, home care, nursing home	172066

or community care/ or nursing home/		
20. 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19	community care, community health nursing, dental care, doctor, elderly care, family, general, general practitioner, health, health care, health care delivery, health care quality, healthcare, home care, mental health, mental health care, mental health service, nursing home, oral, practitioner, primary health care, scheme, secondary health care	1089464
KEYWORDS FOR BARRIERS		
21. barrier.mp.	barrier	195864
22. barrier*.mp.	barrier*	300403
23. impediment.mp.	impediment	5111
24. Challenge*.mp.	challenge*	618233
25. obstacle*.mp.	obstacle*	47375
26. hurdle*.mp.	hurdle*	11349
27. difficult*.mp.	difficult*	721874
28. issue*.mp.	issue*	573255
29. exp trust/ or mistrust.mp.	mistrust, trust	13558
30. risk factor.mp. or exp risk factor/	factor, risk, risk factor	926070
31. obstruction/	obstruction	17967
32. 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31	barrier, barrier*, challenge*, difficult*, factor, hurdle*, impediment, issue*, mistrust, obstacle*, obstruction, risk, risk factor, trust	2956693
KEYWORD FOR ACCESS		
33. exp health care access/ or access.mp.	access, health care access	376847
34. utilization.mp. or hospital utilization/ or health care utilization/	health care utilization, hospital utilization, utilization	315158
35. availability.mp. or exp health care availability/	availability, health care availability	222909
36. exp health care access/ or access to information/ or accessibility.mp.	access to information, accessibility, health care access	104397
37. affordability.mp.	affordability	4204

38. health service/ or health care disparity/	health care disparity, health service	161005
39. health care delivery/ or inequality.mp.	health care delivery, inequality	168310
40. 33 or 34 or 35 or 36 or 37 or 38 or 39	access, access to information, accessibility, affordability, availability, health care access, health care availability, health care delivery, health care disparity, health care utilization, health service, hospital utilization, inequality, utilization	1132596
COUNTRY		
41. exp Scandinavia/	Scandinavia	185386
42. norway.mp. or exp Norway/	Norway	57479
43. sweden.mp. or exp Sweden/	Sweden	111454
44. Denmark.mp. or exp Denmark/	Denmark	69946
45. 41 or 42 or 43 or 44	Denmark, Norway, Scandinavia, Sweden	265564
46. 9 and 20 and 32 and 45	barrier, barrier*, challenge*, community care, community health nursing, Denmark, dental care, difficult*, doctor, elderly care, emigrant, emigration, factor, family, foreign-born, general, general practitioner, health, health care, health care delivery, health care quality, healthcare, home care, hurdle*, immigrant, immigrants, immigration, impediment, issue*, mental health, mental health care, mental health service, migrant, migration, mistrust, Norway, nursing home, obstacle*, obstruction, oral, practitioner, primary health care, risk, risk factor, Scandinavia, scheme, secondary health care, Sweden, trust	**189**

Appendix 4: Search strategy - Ovid MEDLINE

POPULATION		**Results**
1. immigrant.mp. or exp "Emigrants and Immigrants"/	emigrants and immigrants, immigrant	17420
2. migrant.mp. or exp "Transients and Migrants"/	migrant, transients and migrants	14941

3. foreign-born.mp. or exp "Emigration and Immigration"/	emigration and immigration, foreign-born	26887
4. 1 or 2 or 3	emigrants and immigrants, emigration and immigration, foreign-born, immigrant, migrant, transients and migrants	49500
KEYWORDS FOR HEALTHCARE SERVICES		
5. exp Primary Health Care/	primary health care	135613
6. secondary healthcare.mp.	secondary healthcare	216
7. exp Dental Care/	dental care	30911
8. Dental Care/ or exp Oral Health/ or Dental Health Services/	dental care, dental health services, oral health	33970
9. exp General Practitioners/	general practitioners	5760
10. family doctor.mp.	family doctor	2560
11. Health Services for the Aged/ or Geriatric Nursing/ or exp Home Care Services/ or Nursing Homes/	geriatric nursing, health services for the aged, home care services, nursing homes	100053
12. exp Community Health Services/	community health services	283098
13. 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12	community health services, dental care, dental health services, doctor, family, family doctor, general practitioners, geriatric nursing, health services for the aged, healthcare, home care services, nursing homes, oral health, primary health care, secondary, secondary healthcare	496034
KEYWORDS FOR BARRIER		
14. barrier.mp.	barrier	154184
15. barrier*.mp.	barrier*	248645
16. impediment.mp.	impediment	4235
17. challenge*.mp.	challenge*	515656
18. obstacle*.mp.	obstacle*	39917
19. hurdle*.mp.	hurdle*	9291
20. difficult*.mp.	difficult*	546970
21. issue*.mp	issue*	469152
22. exp Trust/ or mistrust.mp.	Mistrust, trust	9260
23. exp Risk Factors/	Risk Factors	720837
24. obstruction.mp.	obstruction	185959

25. 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24	barrier, barrier*, challenge*, difficult*, hurdle*, impediment, issue*, mistrust, obstacle*, obstruction, risk factors, trust	2521778
KEYWORDS FOR ACCESS		
26. utilization.mp.	utilization	180708
27. exp Healthcare Disparities/ or access.mp. or exp Health Services Accessibility/	access, health services accessibility, healthcare disparities	339926
28. availability.mp.	availability	212677
29. "Transients and Migrants"/ or Health Services Accessibility/ or "Delivery of Health Care"/ or healthcare access.mp.	access, delivery of health care, health services accessibility, healthcare, healthcare access, transients and migrants	148033
30. affordability.mp.	affordability	3247
31. healthcare inequality.mp. or exp Healthcare Disparities/	healthcare, healthcare disparities, healthcare inequality, inequality	12281
32. 26 or 27 or 28 or 29 or 30 or 31	access, affordability, availability, delivery of health care, health services accessibility, healthcare, healthcare access, healthcare disparities, healthcare inequality, inequality, transients and migrants, utilization	777164
COUNTRY		
33. exp "Scandinavian and Nordic Countries"/	Scandinavian and Nordic countries	182843
34. exp Norway/	Norway	35106
35. exp Sweden/	Sweden	67173
36. exp Denmark/	Denmark	46063
37. 33 or 34 or 35 or 36	Denmark, Norway, Scandinavian and Nordic countries, Sweden	182843
38. 4 and 13 and 25 and 32 and 37	access, affordability, availability, barrier, barrier*, challenge*, community health services, delivery of health care, Denmark, dental care, dental health services, difficult*, doctor, emigrants and immigrants, emigration and immigration, family, family doctor, foreign-born, general practitioners, geriatric nursing, health services accessibility, health services for the aged, healthcare, healthcare access, healthcare disparities, healthcare inequality, home care services, hurdle*, immigrant, impediment, inequality, issue*, migrant, mistrust, Norway, nursing homes, obstacle*, obstruction, oral health, primary health care, risk factors, Scandinavian and Nordic countries, secondary, secondary healthcare, Sweden, transients and migrants, trust, utilization	**23**

Appendix 5: Search strategy - PubMed

1.	(((((((immigrant) OR migrant) OR emigrant) OR foreign-born) OR alien)) AND (((((((healthcare access) OR ((healthcare) AND access barrier)) OR ((primary healthcare) AND access impediment)) OR general practitioner) OR dental care) OR ((healthcare services) AND barriers)) OR barrier)) AND ((((Scandinavia) OR Norway) OR Sweden) OR Denmark) AND (("2007/01/01"[PDat] : "2017/08/31"[PDat]) AND English[lang])	**163**

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