Refugees own perceptions of what is good health and quality of life

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Abstract

Background: Immigration into Norway has been increasing the last years and will continue to increase over the years to come. There is an ongoing shift in the society when it comes to culture and ethnicity, where the diversity is getting bigger. A large part of the population are refugees who are a vulnerable group. This part of the population may need different adjustments in society to utilize the services in line with the rest of the population.
To offer the best possible services for all, we need to have knowledge about the different cultures´ perceptions regarding health and quality of life. This can provide valuable knowledge that can be useful in the further development of a multicultural society that is accessible for everyone. By knowing more about other ethnic groups views on health and quality of life, we may easier help them in the process of integration in Norway.
Purpose: The purpose of the study was to explore refugees´ personal perception of what is good health and quality of life.
Material and methods: This was a qualitative study based on semi-structured in-depth interviews and the analysis was facilitated using systematic text condensation as modified by Malterud. Eleven refugees were recruited from one asylum reception center in mid-Norway. The informants were originated from Iraq, Kurdistan, Eritrea, Afghanistan, Iran and Syria.
Results: Perceptions of good health and quality of life was expressed in several different aspects. Physical activity, work, language, social network and access to health services were the ones that stood out as crucial to have a good quality of life. To feel safe and as part of society was also described as important. Experiences from the past and the uncertain situation the participants lived under now had a huge impact on their quality of life and their health situation. To have a good mental health was described as important in this situation, and it was described that there was a clear link between health status and quality of life.
Conclusion: This study gives knowledge about refugees´ perceptions of good health and quality of life. The results correspond to earlier research on factors important for maintaining good health, which is physical activity, work, language, social network and access to health care. Findings also suggest that feeling safe and as a part of society was important elements for the participants´ quality of life and health situation. Regarding the integration process in Norwegian society, this study has shown that one should focus more on linguistic proficiency, early employment, and social networking among the refugees.

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1 Acknowledgements

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2 Abbreviations

EQLS - The European Quality of Life Survey

HRQOL - Health Related Quality of Life

OECD - Organization for Economic Co-operation and Development

QoL - Quality of Life

UDI - Norwegian Directorate of Immigration

UNHCR - The United Nation High Commissioner for Refugees

WHO - World Health Organization

WHOQOL - World Health Organization Quality of Life

3 Introduction

In the last 50 years, we have seen an almost doubling of immigration. Worldwide there are an estimated 191 million immigrants, and 33% of these live in Europe (Shah, 2008).

Immigration to Norway has increased in recent years and will continue to increase over the years to come (Østby, 2015). As of January 1st, 2016, there were approximately 848,200 people living in Norway who have either immigrated themselves (698,500) or who are born in Norway with two immigrant parents (149,600). Together these groups constitute 16% of the population in Norway. At the beginning of 2015, 188 000 people living in Norway have a refugee background, and 138 000 of these have received refugee status. These refugees come from 169 different countries, most from Somalia, Iraq, and Iran (Folkehelseinstituttet, 2015). This means that the population in the country is changing in terms of culture and ethnicity (Statistisk sentralbyrå, 2017).

There has been a lack of coordinated policy approaches to address the health implications associated with modern migration (Zimmerman, Kiss, & Hossain, 2011). Societies are increasingly characterized by diversity, and there is a need for more knowledge to help migrant and ethnic minority groups to increase their participation (Bhopal, 2012). It has been seen that there are differences in terms of health status and views on disease among different ethnic groups (Stoltenberg, 2014). Illness experience is influenced by culture, and the perceptions of quality of life and the ways in which health problems are expressed vary from culture to culture (Kleinman & Byron, 1978). But there is little research done directly on different ethnic groups views on health and quality of life. Perceptions of health vary across individuals and cultures, depending on the meaning and importance people give to it (Phillips, 1990). People offer definitions congruent with their world views, which means there are multiple different ways to look at health. Health serves as one of the matrices of the life process from which other values can be understood (Phillips, 1990).

It will, therefore, be important to explore what people from other ethnic groups, living in Norway, appreciate when it comes to good health and quality of life. This can provide valuable knowledge that can be useful in the further development of a multicultural society that is accessible for everyone. By knowing more about other ethnic groups views on health and quality of life, we can easier help them in the process of integration in Norway**.** In the

last years, countries of the industrialized world have been struggling with the question of how to facilitate the settlement of the growing number of refugees and how to enhance their participation in new societies (Korac, 2003). How to organize the integration of new citizens in a country is therefore a challenging and complex process.

3.1 Who is a refugee and who is an asylum seeker?

The United Nation High Commissioner for Refugees (UNHCR) describes a refugee as; "…someone who has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group" (UNCHR, 2017).

The United Nations Refugee Convention of 1951 and its 1967 protocol is the centerpiece of international refugee protection today. According to their provisions, refugees deserve, as a minimum, the same standards of treatment enjoyed by other foreign nationals in a given country (UNCHR, 2000). People who fulfill the definition above are entitled to the rights and status by the duties contained in the 1951 Convention. These rights include access to the courts, to primary education, to work, and the provision for documentation, including a refugee travel document in passport form (UNCHR, 2000). The definition of a refugee includes specific qualities and circumstances that should provide one with refugee status. However, there are no clear requirements that defines an asylum seeker. The United Nation High Commissioner for Refugees (UNHCR) describes an asylum seeker as "an individual who has sought international protection and whose claim for refugee status has not been determined yet" *(*UNCHR, 2011, p. 3).

The number of people seeking refugee status in Europe has risen over recent years. This is due in large part to war in Syria and Iraq, as well as conflict and instability in countries such as Afghanistan, Eritrea and elsewhere (UNCHR, Undated). 188 000 persons with a refugee background were living legally in Norway at the start of 2015. A total of 138 000 have refugee status, 35 000 (25 percent of the total refugees) have come through family reunification with a refugee, and 15 000 through the establishment of a family with a refugee (Østby, 2015).

3.2 What is health and quality of life

The English word "health" comes from the Old English word *hale*, meaning "wholeness, being whole, sound or well" (Norqvist, 2015, p. 1). The word has a lot of different definitions, depending on the people you ask and the situation. The most used and famous definition was created by the World Health Organization (WHO) and entered into force in 1948: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Norqvist, 2015, p. 1). This definition was supposed to provide a transformative vision of "health for all" (The Lancet, 2009). Another definition used for health is: "Merely the absence of disease or infirmity". Non of these definitions will do in an era marked by new understandings of disease at molecular, individual, and societal levels (The Lancet, 2009). Human health cannot be separated from the health of our living world. Health varies for every individual, and is not a fixed entity. It is not defined by the doctor, but by the person, according to his or her functional needs (The Lancet, 2009).

Quality of life is the general well-being of individuals and societies, but the definitions of quality of life are diverse. It is an elusive concept at varying levels of generality from the assessment of societal or community wellbeing to the specific evaluation of the situations of groups or individuals (Felce & Perry, 1995).

> What people see as the meaning of their lives and the kind of living they consider desirable or undesirable are matters of personal choice. Personal choices are affected by the cultural environment in which people are brought up. Thus one can expect definitions of the quality of life concept to be culturally dependent as well. For example, in some cultures, the quality of life is strongly associated with the degree of satisfaction of material needs. In others, it is associated with the degree to which people succeed in subduing and reducing their material needs (Hofstede, 1984, p. 389).

There exists agreement about that quality of life is multidimensional. The concept may be categorized within five dimensions: physical well-being, material well-being, social well-being, emotional well-being, and development and activity (Folkehelseinstituttet, 2016).

Quality of life is about experiencing meaning, vitality, and satisfaction, security and belonging, about using personal strengths, interest, mastery, and commitment (Folkehelseinstituttet, 2016). Quality of life has also been used as another word for welfare, i.e. the extent to which a person or group of people can be said to have a good life (Barstad, 2016). The quality of life is connected with health gains as better physical and mental health, healthier lifestyle choices, stronger networks and social support (Folkehelseinstituttet, 2016). Liu (1976) claims that there are as many quality of life definitions as people, emphasizing the axiom that individuals differ in what they find important. Although most would agree that 'well-being' is important and a sought after goal, from a cross-cultural view, people differ in their perceptions of its meaning, antecedents and consequences (Ekblad & Abazari, 1999). These issues are especially relevant for the increasing numbers of refugees. In addition to traumatic experiences, refugees experience the psychosocial challenges that all immigrants encounter, related to housing, family life, work, language, culture, prejudice and racism, health and social services (Ekblad & Abazari, 1999). In work with refugees and health is the recognition that there are ethno cultural variations in the concept of quality of life (QoL) central. Western concepts for QoL and health often separate mind, body and spirit, while many of the non-Western societies tend to emphasize holistic integration, mind-body interaction, harmony between the person himself, the living family and ancestors. The fact that QoL is seen as a whole is particularly important when dealing with refugees, not merely focus on separate aspects that are often the case. (Ekblad & Abazari, 1999).

There is a clear link between life quality and health status (Bang & Clench-Aas, 2011). High quality of life reflects both improved physical health and fewer mental health problems and disorders. This is partly because some of the factors that contribute to quality of life seem to protect against mental health problems such as severe depression and anxiety (Bang & Clench-Aas, 2011). These factors are categorized under physical, material, mental, social, and material well-being, together with the extent of personal development and activity (Felce & Perry, 1995). Some factors that are considered to have an impact on quality of life is employment, social networks, social activities, self-identity, financial security and cognitive and physical function (UKEssays, 2013). "Quality of life is dependent upon finding a balance between body, mind and spirit in the self and on establishing and maintaining an harmonious set of relationships within the person's social context and external environment" (Albrech & Devileger, 1999, p. 977). High quality of life can be seen as an important protective factor against mental health problems. Quality of life and well-being seems to have positive effects

on physical health, possibly due to positive effects on social relationships, lifestyle and health behavior, stress, accident occurrence, and general mastery, but potentially also directly on the immune system (Bang & Clench-Aas, 2011). Conversely, poor quality of life indicates that individuals encounter difficulties in their daily life due to illness or other reasons causing dysfunction or subjective hardship (Zeng, Xu, & Wang, 2013). A study conducted on outpatients with depression in China reported that less than 5 % of the depressed patients reported "good" or "very good" QoL, and less than 3 % were satisfied with their general health (Zeng et al., 2013). Bowling and Windsor (2001) conducted a population survey where the aim was to explore people´s perceptions of the important domains of quality of life. The six most commonly mentioned important areas of life listed by the respondents were: Relationships with family/relatives, friends, other people, Finances/standard of living/housing, Own health, Other people´s health, Ability to work/satisfaction with work, and Social life.

There has been established countless tools for documenting the dimensions of quality of life. Some of these measures across diagnoses, while others are specific for different disease groups (Donovan, Sanson-Fisher, & Redman, 1989). There are also differences in the various forms. Some measure quality of life in all aspects of an individual´s existence, while others measure health-related quality of life (HRQOL) (Guillemin, Bombardier, & Beaton, 1993). "Health-related quality of life is a subset relating only to the health domain of that existence" (Torrance, 1987, p. 593). One of the tools established is called The European Quality of Life Survey (EQLS) which analyzes and documents the multidimensional nature of quality of life in the EU (Anderson, Dubois, LeonnÊikas, & Sándor, 2012). The first survey that was carried out in 2003 explores issues among the European citizens linked to employment, income, education, housing, family, health, work-life balance, life satisfaction, and perceived quality of society. Another survey carried out in 2011, gives a picture of living conditions and the social situation in the EU. The meaning of the surveys is to examine trends over time, particularly changes in views and experiences since the onset of the economic and social crisis in Europe (Anderson et al., 2012). The EQLS is a good tool which contributes to monitoring the changes in society and it can also pinpoint emerging trends and concerns for the future (Anderson et al., 2012). Some of the key findings from the last survey is that people with low income are more likely to have experienced negative financial consequences in the previous 12 months, unemployment and long-term unemployment have a huge impact

on the subjective well-being, and that countries that report a better quality of life are those in the northern and western part of the EU and Europe. Looking at the results, it also appears that family continues to play a major role in all countries as the basis of social contacts and the main source of support, and the most vulnerable groups shows the greatest decline in subjective well-being between surveys (Anderson et al., 2012).

The World Health Organization has established an international quality of life assessment called World Health Organization Quality of Life (WHOQOL). The reason why they developed this is because it is important to include a consideration of patients´ quality of life in treatment decisions, approval of new pharmaceuticals and policy research (Kuyken, 1995). There are also a lot of benefits of considering the quality of life form a cross-cultural perspective, which is possible with this assessment (Kuyken, 1995). "Having an international quality of life assessment such as WHOQOL makes it possible to carry out quality of life research collaboratively in different cultural settings, and to compare directly results obtained in these different settings" (Kuyken, 1995, p. 1403). In the development of WHOQOL, quality of life was defined "Individuals´ perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (Kuyken, 1995, p. 1405). The concept was defined like this because quality of life must address individuals´ perceptions of both positive and negative dimensions. The assessment is organized into six broad domains of quality of life: physical domain, psychological domain, level of independence, social relationships, environment, and spirituality/religion/personal beliefs (Kuyken, 1995).

3.3 The quality of life among Norwegians

The word quality of life is ambiguous. In Norwegian, it is common to think of how life is experienced by the individual. It is about the extent to which people "think and feel positive about their lives" (Barstad, 2016). The level of quality of life is high in Norway and other Scandinavian countries compared with many other countries. Norway has a high average earning and low labour market insecurity, as well as low long-term unemployment compared to other OECD countries (OECD, 2016).

In Norway, we have a high life expectancy that keeps increasing and we are ranked at the top in international comparisons of well-being and welfare (Stoltenberg, 2014). But we have seen a growing social inequality in mortality since the 1960s. It may seem as if these differences are beginning to diminish, but as many will live long with sickness and ailments that provide loss of health, new forms of inequality arise. In addition, we get new challenges and opportunities in form of a more diverse society and globalization (Stoltenberg, 2014). Because of globalization a lot of challenges will arise in the Norwegian society. A multicultural society will have a greater need for facilitation because of different needs, views, and cultural beliefs among citizens.

3.4 How moving to a new country affects the health

Refugees are a vulnerable part of the population who have experienced major terrible events which can bring up big challenges when it comes to their health. This part of the population has, therefore, a great need for different health care and other services in the community. Bentham´s theory said that in areas with good medical services and the best conditions, there is a higher prevalence of less healthy migrant population (Nante et al., 2016). This is because migrants have a high prevalence of diseases, which might be the real reason for them to migrate to these areas (Nante et al., 2016). A study conducted on Chinese immigrants in New York showed that women were more likely to report poor mental health, poor physical health, and limited activity days than men (Wyatt, Trinh-Sheverin, Islam, & Kwon, 2014). Because of many terrible incidents and predictability in life, many migrants are struggling with their mental health. Support to find a job, counseling and legal guidance, support to housing, and other services such as literacy classes, school placement and cultural-linguistic mediation, and a specific psychological or psychiatric support is therefor important in their process of integration (Nante et al., 2016). A study conducted in London found that approximately 50% of asylum seekers and refugees suffer from depression, and 14% of these showed psychotic symptoms (McColl & Johnson, 2006).

A systematic review and meta-analysis, including articles and the results of surveys comprising 81,866 refugees and other conflict-affected people, showed that pre-migration stress (traumatic events such as torture and other traumatic events) is associated with post-traumatic stress disorder (PTSD) and depression (Steel et al., 2009). PTSD has been found to be the most common form of mental ill health among refugees, followed by mood disorders.

The literature indicates that increasing levels of trauma lead to higher rates and severity of PTSD and depression (Eriksson-Sjöö, Cederberg, Östman, & Ekblad, 2012). A study conducted on Iranian refugees in Sweden found that improved coping resources, a high sense of coherence, satisfactorily available and adequate attachment and social integration enables resistant individuals efficiently to cope with even severe traumatic events and protect them against the development of psychological disturbances (Ghazinour, Richter, & Eisemann, 2004).

According to a critical review on measuring trauma and health status in refugees, it is revealed that refugees clearly experience multiple stressful events that are associated with adverse health outcomes (Hollifield et al., 2002). Refugees may have increased morbidity, decreased life expectancy, and a vulnerability to medical illness and poor health habits (Hollifield et al., 2002). It seems that moving contributes to an increased risk of mental disorders if this involves fragmentation of social networks, causing a relative degree of isolation (Aahlberg, Aambø, Gihle, & Austveg, 2005). Another factor that play a role in relation to this is a lack of social integration, either in relation to their own ethnic group and/or in relation to the country they are moving to. A third factor is quality of life; the subjective experience of how one copes in different areas of life (Aahlberg et al., 2005). This is something that refugees have to deal with since they have to move away from their family and friends, and everything that they have built up in their life.

By gaining more knowledge about refugees' personal perception of good health and quality of life, we have a better basis for facilitating services in the society for other ethnic groups, not only Norwegians. "What people see as the meaning of their lives and the kind of living they consider desirable or undesirable are matters of personal choice. Personal choices are affected by the cultural environment in which people are brought up" (Hofstede, 1984, p. 389). It is therefore important that we are aware of refugees' personal perceptions of what they think is a good life. By having more knowledge about refugees' views on health and quality of life, we can more easily help them in the process of integration in Norway.

3.5 Main objective

The main objective of this study is to explore refugees´ personal perceptions of what is good health and quality of life.

4 Methods

4.1 Design

This student thesis was a qualitative study based on semi-structured in-depth interviews with asylum seekers living in an asylum reception center in Mid-Norway. The purpose was to explore the individual's personal perception of what is good health and quality of life. The goal was to get a better understanding of what other ethnic groups emphasize about these topics, in order to facilitate the Norwegian society in a multicultural way. Qualitative methods allow for diversity and shades (Malterud, 2013) and were chosen to explore individual perceptions of good health and quality of life, and create an understanding of what each individual emphasize as important.

4.2 Participants and recruitment

The inclusion criteria included asylum seekers living in Norwegian asylum reception centers aged 18 or older. The researcher (TLL) wanted to talk with those who had the highest probability of obtaining a residence permit. This because the purpose of the study was to explore refugees´ personal perceptions of good health and quality of life, in order to facilitate the Norwegian society better in terms of new citizens from other cultures. Asylum seekers who had been refused asylum application were therefore excluded, both due to their vulnerability, and because they are not going to settle down in the Norwegian society and get the same rights as a Norwegian citizen.

The informants in this study were recruited from one asylum reception center in mid-Norway. Personnel at the reception center were contacted and the researcher (TLL) held information meetings about the study for potential participants living in the asylum reception center. After the meetings, those who participated received an invitation letter (APPENDIX 1) and were encouraged to participate in the study. Those who were willing to take part in the study shared their contact information with the researcher (TLL) and interviews were arranged. Due to some difficulties arranging interviews with all of the informants who

already had signed up for the study, personnel at the reception center took contact with some of which were relevant participants for the study and arranged time for interviews. Before starting the interviews, all of the informants signed a consent form as confirmation of their participation in the study (APPENDIX 2).

4.3 Data collection

Data was collected through in-depth, semi-structured interviews ranging from 12-20 minutes. This type of interview was chosen because the goal was to explore the participant´s personal perceptions about the topics. There were 11 individual interviews and all of them were conducted with the use of an interpreter. Ten interviews were conducted with an interpreter in person and one interview with interpreter over the telephone. The interpreter translated everything the researcher said, to make sure the participants understood everything around the study. When the interpreter was there in person, it was easier to describe the goal with the study and to explain the questions asked in several different ways if there were any misunderstanding between the researcher´s questions and the participants understanding of them. Through the interviews, an interview guide was used (APPENDIX 3). The initial question that was asked was: ”Can you describe what you mean is good health?”. The next questions developed based on the information from the first question. If the participants started to talk about problems with their current life situation or other themes outside the research topic, the researcher continued to ask about their perceptions about health and quality of life. All of the interviews tried to focus on the participants´ personal perceptions, but that was a challenge with the participants´ who did not have as many thoughts and opinions about the topics in this study. However, all of the interviews tried to cover all themes in the interview guide. This included questions about: the participants´ opinions about factors to maintain good health, their opinion about good quality of life, and the relationship between health status and quality of life. Moreover, they were asked if their quality of life has changed after their arrival to Norway, as well as what they think Norwegians regard as good quality of life. All of the interviews were tape-recorded and transcribed in words.

4.4 Analysis

Data analysis was done on the basis of systematic text condensation. Systematic text condensation consists of four steps; to get an overall impression, to identify meaningful units, abstracting the content of each meaningful unit, and summarizing the meaning of this (Malterud, 2012). The transcripts were first read through to get an overall impression of the content. The general impression was that the text was about six preliminary themes; Physical activity, Diet, Assurance/quiet life, Work, Access to healthcare, Mental health. Next step was to go through the transcripts and look for smaller meaningful units of interest, in light of the topics from the previous step. Each of these units have a code, and new codes were identified while reviewing all the interviews. Text that was outside the research question was not included in the further analysis. This text included detailed descriptions of diseases and earlier marital relationships. The code-groups were reviewed and divided into subgroups, and the number of subgroups in each code-group was dependent on how big the topic was. Some code-groups were divided into 3 subgroups, while others remained undivided due to the small size initially. The code-group *diet and physical activity* remained undivided, while the one named *safe community with good schemes* where divided into; role in society, feeling safe, and living without war and misery. This part of the analysis was done in Mind Manager (Mind Manager, Undated). Themes and codes were modified along the way, based on the size, content, and how they were associated with each other. Seven code-groups and 12 subgroups were the starting point before the next step in the analysis. The code-groups were named; network, diet and physical activity, safe community with good schemes, work and knowledge, access to healthcare, mental health, views on Norwegians.

Under the next step, a text condensate was written to summarize all of the meaningful units in each code-group. Code groups were further adjusted and the text condensate was restructured. The last edition of the condensate presented seven code-groups and nine subgroups. After this, a good quote was found for each code-group. In the fourth and last phase of the analysis, it was written an analytical text based on the text condensate. Quotes from the original data were used to exemplify and illustrate. The text communicated what the original data told about what was interesting in connection with the study question. Transcripts were read through in order to validate the analytical text and look for contradictions. The analytical text was adjusted and edited several times, also with regard to structure, to achieve the best possible representation in accordance with the data

4.5 Ethical considerations

The study was conducted in understanding with the Norwegian Directorate of Immigration (UDI). The Regional Ethical Committee for Medical and Health Research Ethics (REK) considered this study and conducted that an application was not required. Norwegian Social Science Data of Service (NSD) approved the registration and handling of personal data (APPENDIX 4).

By the end of the interview the interviewer contemplated on whether or not the interview had adversely affected the mental health of the informant. The informants were asked if they found the interview straining, and if they felt the need of seeing health personnel.

5 Results

Eleven asylum seekers from a refugee reception center in Mid-Norway were interviewed. There were three women and eight men between the age of 18 and 50. They came from six countries respectively; Iraq, Kurdistan, Eritrea, Afghanistan, Iran and Syria. Five of the participants were single and the rest were married or had a partner. Regarding education and work, there was a large difference among the participants. Some were highly educated and had extensive work experience, while others had only undergone primary school.
All participants were waiting for a response on the application for a residence permit, and all had stayed in Norway for about one year in the asylum reception center.
During analysis seven themes emerged, representing the informants' own perceptions of good health and quality of life. The themes were titled; diet and physical activity, network, work and education, access to healthcare, health status, safe community with good schemes, Norwegians have a good quality of life. The seven themes are described in detail below.

5.1 Diet and Physical activity

All participants said that being active and having a healthy and varied diet was important for good health and quality of life. One of the participants said that it was natural to have such a lifestyle if one wanted to have good health.

> *To have good health, you have to eat a diet that is varied, with vegetables and fish and meat. And then you have to be active, both physically and mentally.*
> (Male from Eritrea)

A man from Eritrea described that he had had a major change in the quality of life after he came to Norway. He had begun to exercise, play football, and cycling, which he considered essential for his quality of life. Several participants described the importance of being active and in shape to have good health. But, they also pointed out the importance of adequate sleep and rest in relation to the time they were active during the day. It became apparent during the interviews that it was important to be active mentally, not only physically. According to the participants, it was important to be active in the labor market and in society in general, which they believed would affect the psyche and self-esteem of a person in a positive sense.

I think there are three factors that are important in my life to have good quality of life. The first is that I have to be active or working; you need to earn money to support yourself. And the second is that I must be in shape (...) (Male from Eritrea)

5.2 Network

5.2.1 Family

Many participants emphasized that having a spouse or a family to share life with had great importance for their quality of life. Having healthy family relations were described by the participants as important for health, to function in everyday life, and to have a healthy lifestyle. One of the participants said that it does not matter what one has or not, as long as you have a good relationship with the people you associate with and that you are enjoying each others company. According to him people would have a good health if this was the case. Another participant talked a lot about her children and told that without them her life would not have any meaning. The children were her life and gave her quality of life.

My kids are my life. I have nothing more important in my life than them. They give me quality of life. (Female from Syria)

5.2.2 Social network

Having a social network and participating actively in society with other people were also valued highly by many of the participants. Learning the Norwegian language was described as an important part since this was a prerequisite for being able to interact with other people in Norway.

I like to have a social network, I want to talk to Norwegians, but I must first learn the language. (Female from Syria)

Many portrayed that having a good network and being active in the community were important factors for good health. They said that they meant this gave a sense of security and tranquility.

5.3 Work and education

5.3.1 Get a job and the opportunity to establish themselves

Having a job was drawn up as an important factor for good quality of life among the participants. Emphasis was placed on having a steady income and the ability to earn a living and establish themselves in society. Here, the importance of having a job so that they could support themselves and their family members was described, which would help to strengthen family relationships. One of the participants expressed that it was important to have a job to go to or to study. If you did not have something meaningful in your daily life, he said he believed that one would struggle with the psyche. Having financial security was also important for gaining access to what you need if you get sick, but also otherwise. They said they believed having a good economy would have major effects on people´s health.

Several participants described the working conditions in their homeland. There the focus was only on working all time, and to accentuate status. According to them there was a better balance between work and leisure time here in Norway, which was a big difference from their homeland.

> *Here in Norway, it is a little different, that one thinks much about health as well as to earn money.. I think that Norway is best for me*. (Male from Eritrea)

Many told of a past where they did not have any leisure time or time to relax, which they meant was bad considering their health. They said that they were always exhausted and that the only thing that was on their mind was to earn enough money to cover all the expenditures they had.

> *The biggest difference I see here relative to home is that in my homeland the focus is on working and you do not have time to do something fun in your spare time. But here in Norway, they have a balance between working and having other activities in their spare time.* (Male for Eritrea)

One of the participants said that work was one of the main factors that gave life meaning. To get a job here in Norway was essential for many, both to cover subsistence, but also to get a good quality of life. They said that it was important to get help to find a job as this could be

difficult for them after living in the reception center. According to the them this would help them to feel like a part of the society. Most of the participants had a history of working as a large part of their everyday life and was now in a very unusual situation without either work or private residence.

> *Of course, work is very important for me, 70% of my personality is work.* (Female from Syria)

5.3.2 Language

Some described that learning the Norwegian language was important for their expression in society and their quality of life. One of the participants expressed that by learning the language one can perform multiple tasks, wishes, and dreams. She also pointed out that she would be a major asset to the community if she did learn the language.

> *Me as a person will do my best for the community I live in, whether it is here in Norway or in Afghanistan.* (Female from Afghanistan)

Language was described as a peace of mind and as an important factor to feel like a part of society. They said that by learning the language it would be easier to be understood and to access the various rights they have in society.

5.4 Access to healthcare

Having access to health care was described as a precondition to have good quality of life. Several participants described that they had no access to medical and health services in the country they came from and thought this was better organized in Norway. Some pointed out that disease could help to diminish their quality of life, especially if they did not have good access to health care. According to participants, having access to good health care was, therefore, an important factor with an impact on their quality of life.

Several participants spoke about chronic diseases which could be a challenge in everyday life, but some still had a positive view of their situation and did not think it had any impact on their life in general.

As long as it is possible to obtain medicines and you get the medicine it is not a problem. (Female from Syria)

Many believed that one was better equipped to cope with everyday life if one had access to healthcare. But they also believed that they had to do their best on their own to cope with the situation they were in, in order to get a good quality of life. Coming to Norway was described as a positive experience in terms of health care.

Where I come from, there was nothing, but here I get everything. For example, I have a disease, but I did not go to the doctor where I come from. There is no health care to get there, but here I have been to the doctor and got what I need to tackle this disease. (Female from Kurdistan)

Participants described the past in a society with poor rights and conditions, and many expressed a great appreciation for all the services they had accessed after they came to Norway.

5.5 Health status

5.5.1 Connection between mental and physical health

Participants expressed an opinion that there is a correlation between mental and physical health. They emphasized that the mental health status was the most important one and that being active would affect the resources of a human. The participants expressed that they felt that they had more control over themselves and their life with good mental health, which would be positive for their quality of life.

It has to start with what you consider, if you think positive then it is a good thing. Then you can control what you do in your life, then you can decide what is important to you in life. You also have control over what you eat, what is proper to eat. You are able to think more about what you eat and so. (Male from Eritrea)

Participants believed that there was a clear relationship between health status and quality of life. They believed that one can think and plan your life better if you have good health. The

importance of having absence of stress and the ability to take life easy without worry and fear was also emphasized. The situation they were in now, where they waited for a residence permit, created great frustration and concern. They said that this contributed to stress and that it was important to have good mental health in such a situation.
One of the participants also expressed that it was important how he felt in his soul and spirit in terms of his health. He said it was important to have a good feeling in relation to the spiritual in order to make the right choices in life.

5.6 Safe community with good schemes

5.6.1 Role in society and the sense of security

Feeling safe was an important factor in having good health and quality of life.

> *I feel much safer here in Norway, and it makes it easier regarding my mental health. When one feels good in terms of the mental health, one feels healthy and safe.* (Female from Afghanistan)

All participants spoke of a past where they lived with war and misery. They said that this had left a deep impression and created a fear in their lives where survival was mostly what they managed to focus on. Living in a country where one can feel safe and valued were uttered as an important element for good health and quality of life. They described that they appreciated living in a society where one feels welcome. Several participants also described that it is the society that affects whether you have a good health or not.

> *It is the community that helps so that we have a good health .. If you have good schemes in society, it will affect both the physical and mental health.*
> (Male from Kurdistan)

One of the participants uttered that learning the language is important to feel safe and to feel as a part of society. To feel safe was expressed as more important than money, since money can not create security, but having a good economy was mentioned by several as an important factor for good health.

Another one said that good facilities for the residents of the community were involved in influencing the quality of life. He meant that avoiding class distinctions and having a society with equality was very important in order to achieve the quality of life one would expect. Many described that there was a link between good health and playing a good role in society. They said that with good health one can play a good role as a fellow human in society, and have the ability to see and help others around them. According to several participants, equality and human rights had a great impact in relation to feeling valued and seen in society, which also had an impact on their quality of life.

5.6.2 Live without war and misery

To live a life without war and misery was for several of the participants a prerequisite for good health and quality of life. They said it was difficult to take care of their health when living in a country with unrest and unpredictability. The focus was on survival.

> *(...) because we live in fear all the time and all you want is to survive. You do not think about how to have a quality of life then...* (Female from Kurdistan)

Many told that living in a peaceful country helped them to provide a good quality of life and sense of security. In addition, to know that they could get help from the state if any problems occur was a sense of security that had a positive effect on their health.

5.7 Norwegians have a good quality of life

5.7.1 Leisure time

According to participants, Norwegians appreciate being active in their spare time. They said that Norwegians in general like to go hiking, play football, and stay active. According to the participants, Norwegians are good in having a balance between leisure and work, which they meant was important for maintaining good health and a healthy lifestyle. They said that they thought this kind of lifestyle was possible to have in Norway compared to their home countries, and they meant that this was positive for their quality of life.

5.7.2 Laws and rights

Many participants talked about that Norwegians are good at following rules and regulations, and that they felt this was one of the reasons why Norwegians have good quality of life.

Several said they believed that Norwegians are very enlightened and have a lot of knowledge, which helps to provide the population with good health. It was also expressed that education and the opportunity to acquire knowledge has a major impact on Norwegians' lives.

> *I think knowledge is very important, and that laws and rules that exist in Norway are very good, and that everyone follows them. (...) Then there are different things that exist in Norway that everyone follows. And from the first day they go to school, so that they learn about health and how to be part of a society, but that´s not that way in my country, they do not have such teaching there.* (Male from Afghanistan)

Many described Norway as a country with a lot of possibilities to live a good life. Several of the participants emphasized that they did not have good quality of life in their home countries due to the circumstances and the governance, but they saw a bright future in Norway if they were granted residence permits. To obtain a residence permit was linked to better quality of life for all participants. If they were granted residence permits, they could finally feel safe and begin to establish a new life. They thought the situation they were in now was injurious to their health.

> *What I said, that for me it is important to have a good mental health. Now for example, I have a daughter of 16 years old that makes me a little stressed. I feel a certain responsibility, as a single mother.. To me, it means a lot if we get a residence permit so that we feel lighter, and then we will also feel secure.* (Female from Iran)

What also was expressed among the participants was that Norwegians respect each other and appreciate the rules and regulations that exist in society. One of the participants said that this was something he appreciated about Norway and that this was not the case where he came from.

> *They (Norwegians) follows rules that exist, such as when to cross the street, they use pedestrian crossings. They are neat, but it's not like that in my home country. They only think of themselves and do not think about laws and regulations like here in Norway.* (Male from Afghanistan)

One of the participants said that she had seen that Norwegians have access to healthcare and education. She expressed that this was not the case in her homeland but an option they had in Norway. According to her, this was an important factor for maintaining good health and quality of life. Another participant said she thought good quality of life for Norwegians were to complete their education and have a quiet and safe life. She said she believed that this was something Norwegian citizens had the opportunity to do, and this would lead to a better quality of life. Education and safety were highly regarded as important for a good life, and they meant that this was possible to accomplish in Norway.

6 Discussion

6.1 Summary of results

Perceptions of good health and quality of life was expressed in several different aspects. Physical activity, work, language, social network and access to health services were the ones that stood out as crucial to have a good quality of life. To feel safe and as part of society was also described as important. Experiences from the past and the uncertain situation the participants lived under now, had a huge impact on their quality of life and their health situation. To have a good mental health was described as important in this situation, and it was described that there was a clear link between health status and quality of life.

6.2 Having an active lifestyle and a balanced diet

Having an active lifestyle and a balanced diet was described as important factors for good health. Several of the participants had had a change in their lifestyle after they came to Norway, something which they believed had a positive impact on their quality of life. Being physically active are well documented to have positive effects on health (Paluska & Schwenk, 2000). Having a lifestyle with moderate amounts of physical activity have been shown to reduce the risk of premature mortality from all causes, and specifically from coronary heart disease (Paffenbarger, Hyde, Jung, & Wing, 1984; Paffenberger, Hyde, Wing, & Hsieh, 1986). Studies has also shown that physical activity promotes psychological well-being and self-esteem, and reduces feelings of depression and anxiety (Keim, Blanton, & Kretsch, 2004). Our study showed similarities with these studies, where the participants said that physical activity was important to maintain a good health. According to the participants, it was also important to be active mentally, with having a job and socializing with others.

6.3 Healthy relationships with family and friends

In our study, the participants emphasized that it was important to have a good relationship with both family members and other people they interact with. Cohen & Wills (1985) suggests that the presence or absence of social relationships affects physiological mechanisms, which relate to health outcomes, either directly or through the mediation of

psychological or behavioral processes. Lack of positive social relationships leads to negative psychological states such as anxiety and depression (Cohen & Wills, 1985). According to Burman & Margolin´s (1992) review, many studies show evidence that marital status may relate to health status. Being married is considered as social support which promote well-being regardless of stress. Lack of a marital relationship could be a source of environmental stress (Burman & Margolin, 1992). This is in line with what the informants in our study expressed. Many of the informants emphasized the importance of having a spouse or family members to get support from and socializing with. This gave them a sense of security, better health, and quality of life. Greater social integration, primary ties with spouses, children and / or other supportive individuals have been found to be a protective effect on the risk of depression (Seeman, 2000). In the process of integrating new refugees in Norway, one should, therefore, keep in mind the importance of having a network to get support and courage from. This can be helpful for the refugees when they are in a difficult period where everything is new and unfamiliar. There is evidence that supportive interactions among people protect against health consequences of life stress (Cobb, 1976). Social support can also protect people from depression, alcoholism, and the social breakdown syndrome when going thorough big crisis in life. It may therefore be beneficial with further research on having a supportive network when one have to escape from a country and integrate into a new culture.

There is evidence that social network affects people´s health, but also enables people to become part of the social structure to which they belong (García, Banegas, Pérez-Regadera, Cabrera, & Rodríguez-Artalejo, 2005). García and colleagues study on social network and health-related quality of life in older adults, shows that HRQL is lower among those with a poorer social network, approximated by a lower frequency of contact with family and friends. Moreover, it shows that a low frequency of relationships with friends is associated with a decline in quality of life (García et al., 2005). As reported in our study, having a social network was valued highly among the participants. They had an opinion about that this had a huge impact on their health status. Positive effects of a social network can be explained by its ability to mitigate stressful circumstances, due to the individual perception of being supported and provided company and assistance when needed (Berkman & Glass, 2000). It also creates a sense of belonging and integration, in addition to security (Achat et al., 1998). We can therefor conclude that having a social network is important when one is trying to

integrate in a new society. This research thus emphasize how vulnerable single refugees are and how important it is for them to get a social network. The measures for this should already start at the reception centers, by focusing on common activities so that people get the opportunity to get to know each other. One should have a greater focus on the individual's social network and be aware of how important it is according to people´s health status. Refugees are especially vulnerable according to having a social network as they often have experienced traumatic events. Social integration enables individuals to efficiently cope with such events and protect them against the development of psychological disturbances (Ghazinour et al., 2004). Further research is required on the relationship between a good social network and health status of people settling in a new country.

6.4 Having a steady income and learning the language

Participants in our study expressed the importance of having a job and a steady income to support and take care of their family. This was also emphasized as a factor that gave them a better quality of life and the opportunity to establish themselves and feel like a part of society. Within a society, people's health are correlated with income (Marmot & Wilkinson, 2001). A person´s income is supposed to satisfy basic needs, but it also serves as a social, psychosocial, and symbolic purpose. The income is expressing a person´s identity, and self-image is enhanced by possessions (Marmot & Wilkinson, 2001). One of the participants in our study also pointed out the importance of having a job in order to stay healthy. He said he believed that people without a job would struggle mentally as they did not have anything meaningful in their daily lives and not a steady income. This statement is confirmed and supported in Patel´s study where it is said that poverty, low education, gender disadvantage, conflict and disasters are the major social determinants of mental disorders (Patel, 2007). People who live in poor income groups, those who are faced with economic difficulties, those who face hardships in acquiring basic needs for survival and those who are less educated, are at much greater risk to suffer mental disorders (Patel, 2007). Refugees are a vulnerable group who often suffer from mental disorders after many terrible incidences in their earlier life. Support to find a job is therefore an important factor to consider in the integration process (Nante et al., 2016). Analysis done by Frank (2010) asserts that richer people are, on average, more satisfied with their lives than their poorer contemporaries.

A study conducted on people with intellectual disability showed that those placed in open employment reported statistically significant higher quality of life scores, empowerment/independence and social belonging/community integration (Kober & Eggleton, 2005). Previous research has also shown that unemployment is associated with worse mental health at the individual level, poorer self-reported health, higher rates of all-cause mortality, as well as limiting and long-term illness (Bambra & Eikemo, 2009; Montgomery, Cook, Bartley, & Wadsworth, 1999). More research is therefore needed on the relationship between having a job and the quality of life when one is integrating in a new society. In practice, this means that new citizens from other countries should have the opportunity to employment as soon as possible after their arrival to the country. If not, they may be feeling that their days are not filled with something meaningful, which is not healthy considering their mental health and general well-being. Considering the findings of this study and previous studies, it would be beneficial to investigate what migrants are thinking about their work-situation when they are settling in a new country. Would they like to get a job as soon as possible when living at the reception center, or would it be too early considering their situation with the residence permit? My opinion is that politicians should invest more time in motivating people to get a job. Today's situation is that many refugees does not get a job, but rather receive funding from the government. This is closely related to that many refugees´ have lack of or weak connection with the workplace and few have earned social security rights. Some groups of refugees and family reunions also lack the qualifications required for participation in Norwegian labor market (Dokken, 2015). At the reception centers one can focus more on engaging refugees in different activities. It does not have to be advanced activities, but small steps to avoid a day without meaningfulness. This may make it easier for them the day they are moving from the reception center, as they already are used to having a daily life with different tasks. It will be interesting for future research to assess whether early employment among refugees´ in the host country affects their health and overall well-being, and if this affects their ability to integrate into the new community.

Participants in our study also expressed the desire to have a good balance between work and other activities in their leisure time, something that was not the case in their home countries. They said that this was important for them to maintain a good health, and they hoped that they had an opportunity to this in Norway. Previous research that looked at the relation between work-family balance and the quality of life, showed that quality of life was highest for those individuals who spent more time on family than work and was lowest for those who

spent more on work than family (Greenhaus, Collins, & Shaw, 2003). Studies show that individuals can – and should – demonstrate equally positive commitments to different life roles. This means they should hold a balanced orientation to multiple roles (Greenhaus et al., 2003). In the western industrial society, a higher proportion of women from all social classes are engaged in paid employment (Guest, 2002). The pressure and demands of work, reflected in longer hours, more exhaustion and the growth of work in the evenings and weekends, tend to leave less time for quality time with family. Consequences of this include increases in juvenile crime, more drug abuse, a reduction in concern for community and in community participation, and less willingness to take responsibility for care of elderly relatives and for the disadvantaged (Guest, 2002).

This shows that having a balanced work-life has benefits, not only for the individual, but also for the society. Further research is needed on this subject to see if having a balance between work and other activities have positive effects on refugee´s self-esteem and behavior in society. By having more knowledge about it, people can be more aware of the importance of balancing different roles in their life and the positive effects of it. With regard to refugees, it will be important to focus on the different roles they have had earlier in their lives to avoid excessive changes when coming to a new country. Both employment and social networks are considered to have an impact on people´s quality of life (UKEssays, 2013). Ensuring that refugees have meaningful activities in their daily lives, but also time for family and other social networks are therefore crucial to their health and quality of life.

Learning the language was expressed as an important factor in our study. Participants pointed out this as crucial for feeling as a part of the society and for their quality of life. They said that this would make it easier to be understood and make an effort for the community they lived in. Both learning the language and having a job goes under the social determinants of health (Los Angeles County Department of Public Health, 2013). Educational level, employment, income, family and social support, and community safety are all components of social determinants of health (Los Angeles County Department of Public Health, 2013). Inequities in the structure of these can mean the difference between life or death, or a life filled with good health or one with disease and poor health (Booske, Athens, Kinding, Park, & Remington, 2010).
Studies has shown that language is one of the most potent challenges when people are settling in a new country. Lack of language skills weakens people economic opportunity, access to

social resources, and the opportunity to participate in the power structure of the country they are settling in (Dustman & Fabbri, 2003; Hou & Beiser, 2006). Proficiency in the language of the receiving society has huge effects on economic and social integration of the people, as well as newcomer well-being. Language can be one of the decisive factors for getting a job when one does not have a family or community network to rely on to help find employment. Linguistic competence also helps ensure well-being and preventing isolation of elderly refugees (Hou & Beiser, 2006). This supports the results of our study, where the participants expressed the importance of learning the language in order to participate more actively in society.

By focusing on language skills in the integration process of new refugees, people will be able to acquire a larger network and become a stronger resource in society. In Britain, refugees have made huge contributions to the society (British Refugee Council, 2002). Over the years they have had a positive economic impact, bringing new skills and ideas to the country, and using their resources and determination that drove them to seek asylum, in the British workplaces (British Refugee Council, 2002). For further development of a good integration system, it should be kept in mind that refugees are a resource for the society. Facilitating asylum seekers´ and refugees´ access to employment will benefit a country's economy, can create more jobs and provide people that have fled from their home country a chance to rebuild their lives. This means that the country will have a larger working capacity and a larger proportion of the population in the labor market, which will provide economic growth and hopefully better health among the population. It should, therefore, be done more research on the link between linguistic proficiency and employment.

6.5 Good mental and physical health

Our results showed that the participants emphasized that there is a clear correlation between mental and physical health. But they emphasized that having good mental health was the most important, because then you are able to take the right decisions in life. The WHO have made a proposition that there can be "no health without mental health" (WHO, 2005). Evidence has shown that there is a clear connection between mental illness and other health conditions (Prince et al., 2007). Mental disorders increase the risk for communicable and non-communicable diseases, and conversely many health conditions increase the risk for

mental disorders. This is complicating the process of help-seeking, diagnosis, treatment, and influences prognosis (Prince et al., 2007). The results from our study showed the importance of being active to take care of their mental health and their resources. Physical activity has shown to have a positive impact on mental health and psychological well-being (Fontaine, 2000). It appears that it improves the symptoms of depression, anxiety, and panic disorders. Physical activity is also increasing a person´s perceived energy level and self-esteem (Lane, 2008). This emphasizes the importance of having an active lifestyle, as many refugees may not have when they come to a new country where the surroundings are unknown, they have a small network and poor language proficiency.

Absence of stress and having the opportunity to live without worry and fear was also pointed out as crucial for having good quality of life. It is not surprising that this comes out of the result of our study, regarding the participants´ past with living in areas plagued with conflict and war. Prolonged stress includes consequences of adverse psychological and physical health effects, as well as increased risk of premature mortality (Braveman, Egerter, & Mockenhaupt, 2011). Keller and colleagues (2012) found that people who reported a lot of stress and perceived that stress affected one´s health increased the risk of premature death by 43%. Refugees are a vulnerable group who have to undergo a lot of changes when coming in contact with a new culture. Cultural and psychological changes that this group have to undergo refers to acculturative stress (Crow, 2015). This type of stress often results in a particular set of stress behaviors, including anxiety, depression, feelings of marginality and alienation, and identity confusion. Acculturative stress may underlie a reduction in the health status of individuals, including physical, social, and psychological health. Stress that is unique to this group of people is also stress related to difficulties with language and varying customs (Crow, 2015). Changes in socioeconomic status, level of education, and language proficiency in the host country are also major stressors refugees experience when coming to a new country. The intensity of this type of stress depend on many factors, but one of the most important ones is the host country´s political and social attitudes toward the new citizens (Crow, 2015). Giving provision of social and economical support is an important aspect to consider to ease the process of integration. Providing good language lessons and the ability to work are two important elements that should be focused on in the integration process of refugees. This can make it easier to feel like a part of society, and perhaps avoid the major cultural and psychological changes. Further research should focus on how the host countries can avoid this type of stress for new citizens.

6.6 Access to healthcare

According to the participants in our study, one was better equipped to cope with everyday life if one had access to healthcare. In their home country, they had not had access to the medication and health care they needed when they were sick, which they thought was a basic need for having good health. When people can not afford to pay for health care, the consequences are worse health, less productivity and income, and increased poverty (Wagner et al., 2011). Wagner and colleagues' study showed that positive overall perceptions of public health care service delivery in a country is associated with better access to acute and chronic care, less risk of potentially catastrophic health care spending, and less use of negative financial coping strategies. This indicates that having no access to healthcare will have major impacts on a person´s life. As the participants in our study said, as long as one has access to medicines and healthcare, there is not a problem being sick or having a chronic disease. Having the opportunity to see a doctor when feeling sick was described as a precondition for having good quality of life. The participants felt that their access to healthcare had improved considerably after their arrival. Norway has one of the best healthcare systems in the world, where every citizen and resident of the country are entitled to healthcare (Statens legemiddelverk, 2016). It consists of both public and private facilities, where the public services are subsidized by the government and the private is funded by patient fees. The participants in our study emphasize the importance of good access to healthcare, which is already well organized in Norwegian society and can have a major impact on people´s health and quality of life.

6.7 Living in a country that is facilitated for the citizens

Our results showed that participants emphasized a society where one can feel safe. They said that this was important in regards to their health and quality of life, as they where accustomed to live in war-torn and conflict-ridden nations. Research has shown that individuals will be healthier if they live in walkable and safe communities. This will lead to lower levels of obesity, which in turn contributes to lower levels of weight-related chronic conditions and improved overall health (Doyle, Schwartz, Schlossberg, & Stockard, 2007). Participants in our study uttered that it is the society one lives in that affects people's health, both physically and mentally. It is shown that individuals who live in counties that are more walkable and

have lower crime rates tend to walk more, and as a result have lower body mass indices (BMIs) than people in less walkable and more crime-prone areas (Doyle et al., 2007). Being able to walk and exercise in the community one lives in is not only beneficial for physical health. Increased activity has been shown to reduce depressive symptoms (Paluska & Schwenk, 2000). Anxiety symptoms and panic disorders also improve with regular exercise (Paluska & Schwenk, 2000).

Having a society with equality and no class distinctions among the citizens was portrayed as important elements to feel appreciated and seen in society. They said they believed that the state had an important role in avoiding large differences between the rich and poor in society. This corresponds to findings from research that says that there is a strong relation between a society´s income distribution and the average life expectancy of its population (Wilkinson, 1992). Countries with a more egalitarian income distribution are more likely to have better public services which benefit the population´s health (Wilkinson, 1992). Research has shown that the association between class and cultural lifestyle in contemporary society is weak. The middle class perspective assumes that in postindustrial societies the majority of individuals share a common living standard and that lifestyle disparities between classes are small (Katz-Gerro, 2002). As a person with refugee status, you also have different rights in society, including right to school, work, and healthcare (UNCHR, 2000).

Human rights were also expressed as something that affected the quality of life of the participants, as they help avoid discrimination and differential treatment. Human rights defines all people´s rights to what is absolutely fundamental in order to live a life in security and dignity. They are universal, which means that they apply to all without exception (Amnesty international, Undatet). Living in a country which has ratified the principles of human rights enables the citizens with good health and quality of life. Our results showed that living in a peaceful country without war was highly appreciated, which is in line with living in a country with human rights.

6.8 Discussion of method

6.8.1 Sample and recruitment

Two recruitment strategies have been used in this study. The first one was recruitment through an information meeting held by the researcher (TLL) followed by delivery of an information letter about the study. It was the desire that participants that were at the information meeting should sign up solely based on their own assessments of the inclusion criteria. This might have excluded those with poor language proficiency and illiteracy. These individuals might experience more difficulties when it comes to integrating into Norwegian society. These individuals may have other perceptions about what is important when it comes to having a good quality of life. This will, therefore, be limiting the width of the data material. Moreover, this type of recruitment might also have excluded individuals who are struggling with mental health issues and passivity, and thus confined the variation within the data material. Contrary, individuals who have a lot of interest about health and general well-being, are general more likely to take part in such studies. Individuals who have opinions on these topics also often have a background in health, which can lead to less generalized and transferable results. The non-purposive sampling might, therefore, have led to biased results.

Due to problems with getting in touch with the participants that already had signed up for the study, another recruitment method was required. Participants were therefore requested through oral invitations made by the personnel at the reception center. Personnel´s sense of who was suitable for the study may therefore have affected the result, since this recruitment was more purposive. The direct request may also have seemed intrusive, and led to participants feeling they had to participate. This is an ethical issue, but however, this recruitment method was required as it was difficult to make contact over telephone with those who had already signed up for the study. Due to time constraints, this was the easiest way out to get in touch with those who lived at the reception center. But the personnel at the reception center had been informed about the inclusion criteria for the study and had, therefore, an idea of who was suitable to participate.

Due to difficulties recruiting informants and limited time, we have not been able to interview more than eleven asylum seekers, which means the data material is not as comprehensive as it could have been. This may affect the transferability of the results to other asylum seekers. The recruitment of informants was not done by purposive maximum variation sampling, but

by availability. This led to a low number of informants which could have affected the results and made them less generalizable. With such a limited number of informants, it is always a risk that the results are more a personal perception rather than something that represents the whole group.

The results may have been different if we had chosen asylum seekers from several different reception centers, and one could also include those who have already been granted asylum. Nevertheless, there is great variation in the participants in terms of gender, age, and nationality. Results say something about what factors that the participants mean is important for maintaining good health and quality of life. But, by including refugees who have been granted residence permits and lived for a while in Norway, we might have got answers that have a greater transfer value in the integration process for newly arrived refugees. The informants we talked to at the reception center had little insight into Norwegian society and had difficulty seeing what they could expect from the society if they got a residence permit. The answers they gave were therefore largely related to their homeland, where they lived in poor conditions and with few rights. When they were asked what they put in the terms good health and quality of life, there were many who had difficulty providing general replies without linking it to the surroundings they were accustomed to living in.
But the purpose of the study was to obtain a personal perception of good health and quality of life among refugees, and therefore we feel that the selection of informants was hitting the target audience of the study. Answers we got were the informants' personal perceptions about the topics in the study, and that was the intention. The validation of the study is therefore good.

6.8.2 Data collection

Data collection was done through individual qualitative interviews where the goal was to reveal personal perceptions about what was important for good health and quality of life. The individual interview gives the opportunity to delve into what the informant tells you. Focus group interviews could also be used, but it places high demands on group dynamics and the interviewer (Malterud, 2013). This could be challenging with this group of participants, who have experienced much tragedy in their past, and for the researcher who did not have a lot of experience. Considering the use of interpreters, it would also have been a challenge to be in a group, since there was a need for different interpreters for the various participants. This could have led to confusion and a lot of noise in the group, since everything that had been said

would have had to be translated into many different languages. Experience from this study was that one-to-one relationship led to an openness of each individual's personal nature, which may be held back in a group. This method allowed the participants to express their personal opinions on the subjects. It is unclear whether the participants would express themselves equally in a focus group, or if they would have held back their opinions. The researcher experienced the setting as a good base for the interview, as this was a familiar atmosphere for the participants. But since the researcher was an unknown person for the participants and they had not been involved in anything like this before, the researcher had a feeling that someone was a little insecure and nervous before the interview. Many of the participants expressed that they were worried about the situation they were in, in terms of residence permits, and the researcher thought some of them were worried that the interview would have an impact on it. This may have lead to the participants failing to express themselves properly. Regarding questions about what participants let in the term good health and quality of life, it happened several times that it was talked about their health situation and quality of life in their home country, and not directly about their perceptions of the terms. It was therefore sometimes difficult to obtain their personal perceptions about what is good health and quality of life.

The data collection was conducted by one student studying Global health. Feedback has been given by the supervisor, but the student is the only one who has been present during the interviews. This might have weakened the results. The researcher's background as an occupational therapist and with a general interest in having a healthy and active lifestyle may have had an impact on the results. With this background knowledge, the researcher's view of what is good health and a healthy lifestyle may have affected the questions asked during the interviews. A researcher will always enter a field of research with certain opinions, and have beliefs about how, and what, data should be investigated (Malterud, 2001). The researcher’s motivation, perceptions, and knowledge about the field might have had an impact on the results being reached. The fact that this is the first research completed by the researcher may also have had an effect, since the researcher does not have any experience with such work previously.

6.8.3 Use of interpreter

In all of the interviews, an interpreter was used, either present or by telephone. This was done because of poor English and Norwegian language proficiency among informants. It was also done to avoid misunderstandings and to let informants express themselves in their mother tongue for the best possible quality of the data. But there are many disadvantages in using an interpreter. First of all, none of the interpreters had Norwegian as their mother tongue, which may have led to misunderstandings between the researcher and the interpreter. During the interviews, the researcher sometimes felt that descriptions and statements were shortened and information was filtered through the interpreter. Several times the researcher felt that the interpreter and the informant had further discussions regarding the questions without this being literally translated. Moreover, the use of interpreters might have influenced the honesty and depth of the interviews due to confidentiality issues. It is sometimes difficult to find an interpreter who is outside the informant's social group since the immigrant communities are small. This may have affected the result, both in terms of misunderstandings of the questions, and willingness to share their opinions regarding the topic.

6.8.4 Analysis

Analytical work was completed by systematic text condensation (Malterud, 2012). The method is suitable for the compilation of information from various informants, cross second paper analysis, and is a good tool for researchers with little experience. This method has a descriptive approach, presenting the experience of the participants as expressed by themselves, rather than exploring the possible underlying meaning of what was said (Malterud, 2013). There was only one person who conducted the analysis. It is positive in terms of a good overview of all the steps in the analysis process and a good overview of the work being done. But it can also lead to a subjective perception of data, which may affect the results (Malterud, 2013). Frequent checks were therefore made of snippets and results against transcripts and audio recordings to ensure that the results were as similar as possible to what the participants had expressed. Input and monitoring from the supervisor also added the analysis more depth and a wider perspective.

6.8.5 Ethical considerations

Asylum seekers may be considered a vulnerable population due to their life experiences and uncertain life situation. All participation was voluntary and none of the potential informants were asked more than once to participate. This was done to secure the integrity and to ensure that those who participated were willing to share their opinions on the topic. All participants had the opportunity to withdraw from the study at any point without giving any reason. The interview was focused on the participant´s perceptions of good health and quality of life, and tried to avoid bringing up the participant´s current health condition and/or earlier life experiences. This was done to avoid re-traumatization or bringing up private topics the participants did not want to discuss.

6.9 Conclusion

This study gives knowledge about what refugees experience as important for good health and quality of life. The results correspond to earlier research on factors important for maintaining good health, which is physical activity, work, language, social network and access to health care. Further the findings suggest that feeling safe and as a part of society was important elements for the participants´ quality of life and health situation. Because of the uncertain situation they were living under now, having a good mental health was considered as crucial. The present study clarifies to a greater extent the importance of a good social network and employment. Having a fixed income was crucial for the participant´s mental health and for feeling like being a part of the community. It is therefore important that the Norwegian integration system focuses on these elements when new refugees come to the country. Furthermore, the findings suggested the importance of good language proficiency, both to be able to communicate with people and to increase the chances of getting a job.

Regarding the integration process in Norwegian society, this study has shown that one should focus more on social networking, early employment, and linguistic proficiency among the refugees. Further research is required on the relationship between these factors, quality of life and good health, as this was a study conducted with few participants. Similar studies should be done on refugees who have been granted a residence permit and lived for a while in Norway. This can help to further develop and improve the integration process of refugees in Norwegian society, and lead to the community being organized in a multicultural way so that everyone feels like a part of society.
This study has identified some perceptions that refugees have about good health and quality of life. However, the knowledge about this is still sparse, and more attention should be given to how different perceptions of health and quality of life affects people´s need in society.

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Appendix 1 Invitation letter

Do you want to participate in a research project about refugees personal perception of what is good health and quality of life?

If you are an aslylum seeker, above the age of 18, live in an asylum reception center and want to share your personal perception about what is good health and quality of life, you are invited to participate. The results from the study might help to improve the Norwegian system by facilitating the services in society for different ethnic groups, not only Norwegians.

In this study we want to explore refugees personal perception of what is good health and quality of life. We want to find out what they emphasize as important when it comes to maintaining good health, and whether they think there is a link between health and quality of life. We also want to find out if refugees have other perceptions of these themes than Norwegians. The aim of the study is to get a better understanding and knowledge of refugees' views on health and quality of life, in order to facilitate the services in society for several ethnicities.

What does participation involve?
You will be asked to take part in an interview with me where you can share your personal perception of what you put in good health and quality of life. The interview will be conducted in your mother tongue, with the help of an interpreter, or in English if you speak English fluently.

You can withdraw from the study at any point without giving any reason. Whether you choose to participate or not will not influence your right to health services or the outcome of the asylum application process. UDI will not get access to information that can identify you.

Anonymisation of the material will be made by December 2017.

If you would like to participate, please send your name and phone number to me in a text message or call me at phone number 416 919 81. You can also send the information in an e-mail to tonjella@stud.ntnu.no. It is also possible to give your name and contact information to personnel at the asylum reception center; they will then pass the information to me.

When I get your contact information I will take contact with you and arrange an interview.

If you have any further questions about the study don´t hesitate to contact me or my supervisor.
Tonje Landsem Larsen at tonjella@stud.ntnu.no or at phone 416 919 81.
Marit By Rise at marit.b.rise@ntnu.no or at phone 993 15 365

Appendix 2 Consent form

Consent to participation in the research project "Refugees personal perception of what is good health and quality of life"

Background
There is so far limited knowledge about refugees´ personal perception about health and quality of life. With little knowledge about different ethnic groups views on health it is also difficult to facilitate the services to meet everyone´s needs. This study aims to understand what refugees emphasizes as important when it comes to health and general well being in life. By knowing more about refugees´ perception about health and quality of life, services in the society have the opportunity to improve their practice and ease the integration process of refugees.

The study is a student research project and will be conducted by Tonje Landsem Larsen, a master student at the Norwegian University of Science and Technology. Dr. Marit By Rise at the Department of public health and general practice will supervise the project.

What does participation involve?
If you decide to participate you will take part in a research interview. The interview will be a conversation between you and the researcher, if required there will be an interpreter present. In the interview we will talk about your personal perceptions of good health and quality of life. The interviews will take about 30 minutes to one hour and will be conducted at the asylum reception center where you live, or at the University campus. The interview will be audio tape-recorded.

What happens to the information about you?
The information registered about you will only be used in this study. Information from the interviews will be treated with confidentiality and processed without name, identification number or other data that can lead to the identification of you. Only authorized personnel involved in the study can access contact information and names of the participants. This will be me, Tonje Landsem Larsen and my supervisor Marit By Rise.
Transcribed interviews will be anonymized, and audio tapes will be deleted when the research project is over. Final papers will not contain information that can identify you.

Voluntary participation
Participation in this study is voluntary and you can withdraw from the study at any time without any negative effects. If this is the case or you have questions about the study, you may contact Tonje Landsem Larsen on phone number 416 919 81.

I have read the information above, or had it explained to me by the interpreter. I have had the opportunity to ask questions about things I found unclear. I am willing to participate in the study.

_____ _____

Date Signature

Appendix 3 – Interview guide

Before I start this interview I would like to make sure that you know that if there are questions you do not want to answer you do not have to. You can stop the interview whenever you want. You can also ask me to turn off the voice recorder if there are things you do not want to be recorded.

Age:
Time in Norway:
Nationality:
Relationship status:
Education/work:

1. How would you describe good health?

2. What factors do, in your opinion, play the most important role to maintain a good health?
Access to healthcare
Exercise
Work
Spare time
Time with friends and family
Hobbies

In Norway we have a term called "life quality". Do you have a similar term in your culture?
What do you feel that this term includes?
What does it mean to have "good quality of life"?
Family
Safety
Freedom
Economy

3. What factors do, in your opinion, play the most important role to have good quality of life?

4. Which factors do you think are important for people to feel well?
Do you think this factors are affected of culture/ethnicity?

5. What do you feel is important to consider in order to maintain a good/healthy life in general?

6. How do you feel the relationship between health status and quality of life is interrelated?
Do you think there is a link between peoples health and quality of life?
Do you feel that health affect peoples quality of life in a better or worse way?

7. What do you think Norwegians regard as good quality of life?

8. Do you feel that your quality of life has changed after you came to Norway?

Do you feel that this interview have been straining in a way that makes you want to see a doctor or other health personnel? In that case, do you want me to help you contact anyone?

Appendix 4 - Approval from Norwegian Social Science Data of Service

Marit By Rise
Institutt for samfunnsmedisin NTNU
Postboks 8905
7491 TRONDHEIM

Vår dato: 17.08.2016 Vår ref: 48933 / 3 / ASF Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 14.06.2016. Meldingen gjelder prosjektet:

48933	*Flyktningers beskrivelser av hva som er god helse og god livskvalitet*
Behandlingsansvarlig	*NTNU, ved institusjonens øverste leder*
Daglig ansvarlig	*Marit By Rise*
Student	*Tonje Landsem Larsen*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 30.12.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Kjersti Haugstvedt

Amalie Statland Fantoft

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Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.