Norges miljø- og biovitenskapelige universitet

Master's Thesis 2021 30 ECTS

Department of International Environment and Development Studies (Noragric)

Racial Discrimination in Norway

Africans experiences while using healthcare services.

Peter Kofi Taadi

MSc. International Relations

The department of International Environment and Development Studies, Noragric, is the international gateway for the Norwegian University of Life Sciences (NMBU). Established in 1986, Noragric's contribution to international development lies in the interface between research, education (Bachelor, Master and PhD programmes) and assignments.

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scoraltaadi@gmail.com

Noragric
Department of International Environment and Development Studies. The Faculty of Landscape and Society
P.O. Box 5003 N-1432 Ås Norway
Tel: +47 67 23 00 00

DECLARATION

I, Peter Kofi Taadi, declare that this thesis is a result of my own research investigations and findings. Sources of information other than my own have been acknowledged and a reference list has been appended. This work has not been previously submitted to any other university for the award of any type of academic degree.

Signature…….

Date……

ACKNOWLEDGEMENT

I owe a debt of gratitude and appreciation to my Supervisor, William Derman, at NORAGRIC. He has been kind, patient and supportive throughout the process of the thesis.

I am also grateful to all the participants who time off their busy schedules to partake in this research.

Lastly, I thank all the NMBU staff and my family for their support and encouragement.

ABSTRACT

The thesis is a qualitative study involving fifteen Africans living in Norway. The study explored their experiences of racial discrimination when using healthcare services. In addition, participants' subsequent use of healthcare services after experiencing racial discrimination, coping strategies and their awareness of human rights laws and institutions were also explored. Ten out of the fifteen participants had experienced some form of racial discrimination. Forms in which racial discrimination was manifested include facial expression, body language and language issues. Participants with family were found to continue to use healthcare services even after experiencing discrimination while those without family stopped using healthcare services and resorted self-medication. Avoidance was the main coping strategy identified by the study. The study makes use of Human Right Conventions and the Critical Race Theory (CRT) to analyze the data. From the human right perspective, the study found that all participants had knowledge about human rights laws and institutions that are supposed to protect them against racial discrimination and to help provide support when they become victims. However, none of the participants have used the services of these institutions. The CRT offers an opportunity for systemic structures that disfavour racial minorities and, in turn, promote racism to be highlighted and brought to the fore. Racial discrimination against Africans living in Norway when they are using healthcare services occurs through systemic structures where language issue is the main discriminating factor. Health facilities should inform immigrants about their right to request for an interpreter if needed when attending appointments. Further a genuine show of interest by policy makers, leaders of health facilities and training of healthcare providers' about racial discrimination can help reduce the canker. The experience of racial discrimination in the healthcare sector is part of a broader racial discrimination issue in Norway.

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CHAPTER ONE

1.0 Introduction

Discrimination is considered as a socially structured action that is unfair or unjustified and cause harm to individuals and groups resulting from specific characteristics including but not limited to gender, age, race, ethnicity, religion, political preference, nationality, sexual orientation or disability (Abramson, Hashemi & Sánchez-Jankowski, 2015; Dovidio, Penner, Albrecht, Norton, Gaertner et al., 2008). It is mainly the outcome of social interactions to protect more powerful and privileged individuals or groups to the detriment of others in society (Luo, Xu, Granberg & Wentworth, 2012). Discrimination can either be perceived or experienced and intentional or unintentional (Andriessen, Fernee & Wittebrood, 2014). Discriminatory episodes may sometimes include events that do not fall under the remits of the law or scientific definitions. Similarly, it can exclude incidences established as discriminatory by law or scientific definitions depending on how individuals characterize the experience (Wong, Derthick, David, Saw & Okaz, 2014).

Discrimination often has slight variations in meaning depending on the contextual application. For example, Norway's 2018 Equality and Anti-Discrimination Act define discrimination as 'direct or indirect differential treatment unlawful'. In this Act, direct differential treatment involves a person being treated less favourably than others in a similar situation due to the discrimination grounds prescribed under the Act, including ethnicity and religion. On the other hand, indirect differential treatment refers to any seemingly neutral provision, condition, practice, action or omission that disadvantages some persons more than others.[1] The Principle of

[1] Equality and Anti-Discrimination Act. Available at **https://lovdata.no/dokument/NLE/lov/2017-06-16-51** retrieved on 12.04.2021

Equality and non-discrimination is enshrined in the 1814 constitution of Norway called «Grunnloven». Section 98 of the constitution explicitly states that 'All people are equal under the law. No human being must be subject to unfair or disproportionate differential treatment'.[2] In order to achieve this constitutional mandate, several measures have been put in place by the Norwegian government.[3] These include the 2018 Equality and Anti-discrimination Act, which broadly replaced earlier separate Acts dealing with equality and non-discrimination. The purpose of the Equality and Anti-discrimination Act includes promoting equality and non-discrimination based on ethnicity, religion and belief. The establishment of the Equality and Anti-discrimination Ombud by the Norwegian government is among the several measures to enhance equality further and prevent non-discrimination. The Ombud strives to create awareness of the rights people have, especially immigrants. Its 2019 focus was mainly on discrimination based on ethnicity and religion. Norway's Penal Code also contains provisions on discrimination. Discrimination based on one's skin colour, nationality, ethnic origin, beliefs, sexual orientation or disability is covered in section 185 of the Penal Code.[4] Further, Norway is a party to the European Economic Area (EEA) and other international conventions against discrimination. The UN International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) is among these.

Despite all these measures put in place by the government and the continued emphasis on non-discrimination in the media landscape, inequality and discrimination are believed to exist to a

[2] Section 98 of the Norway constitution. Available at https://lovdata.no/dokument/NLE/lov/1814-05-17/KAPITTEL_5#KAPITTEL_5 Article 98 retrieved 10.04.2021

[3] The Norwegian Government's Action Plan against Racism and Discrimination on the Grounds of Ethnicity and Religion 2020-2023 (Extracted Version). Available at https://www.regjeringen.no/contentassets/589aa9f4e14540b5a5a6144aaea7b518/action-plan-against-racism-and-discrimination_uu.pdf retrieved 10.04.2021

[4] The Penal Code. Available at https://lovdata.no/dokument/NLE/lov/2005-05-20-28 section 185 of the penal code retrieved 10.04.2021

higher degree in Norway continuously. The integration Barometer 2020 survey carried out at the Norway Institute for Social Research by Brekke, Fladmoe and Wollebæk (2020), revealed that the number of Norwegians who believe discrimination against immigrants has significantly increased threefold over the last six years. The majority of the respondents from the survey believe discrimination occurs mainly with employment, housing and interaction with the police (ibid).

Meanwhile, there has been a continuous upward growth of the immigrant population in Norway. According to Statistics Norway (2018), the 2018 population data shows that immigrants add up to 14% of the population in Norway compared to 6% at the beginning of the millennium. Among all the immigrant groups, people of Polish origin are the largest group comprising 13%. Outside the European Union, most immigrants living in Norway are from countries such as Somalia, Syria, Iraq, Eritrea, The Philippines, Pakistan, Thailand, Iran and Afghanistan (ibid). Among this broader group of immigrants are people from Africa. Countries in this region are noted for their low economic status, political instability and a hub for the world's worst human development and health indices (The United Nations, 2017). A recent study among Africans living in Oslo published by Mbanya et al. (2019), to determine the challenges Africans faces in accessing the Norwegian Healthcare system reveal significant findings related to the present study. Among other factors, many of the participants considered discrimination as a significant barrier to accessing healthcare in Norway. Participants claim to have been discriminated against because of their ethnicity and background. They describe the discrimination in the form of a language barrier, the use of double gloves by nurses when taking blood samples for routine laboratory investigation and unpleasant facial expressions.

Discrimination is among the several essential pre and post-migration factors that have been found to contribute to an increased risk of poor health among immigrants (Chen, Hall, Ling & Renzaho, 2017). While it is well documented that discrimination has increased risk for mental health problems and poorer health outcomes among immigrants living in host countries, available research on racial discrimination have mostly been general, thus touching on a bit of everything, including healthcare. No present study in Norway has solely been dedicated to examining racial discrimination experienced while accessing healthcare services. In order to fill this lacuna, this study sought to examine if and how Africans experience discrimination while accessing healthcare services in Norway. The study focuses on healthcare services received at the family doctor (called 'legekontor' in Norwegian), at the hospital (called 'sykehuset' in Norwegian) and emergency department (called 'Legevakten' in Norwegian).

Healthcare usage is selected for this research because health is a susceptible and essential area where unequal treatment can significantly impact the health of users.

Research questions:

1. Do Africans experience discrimination, and in what forms are these discriminatory acts manifested while using healthcare services, if any?
2. How does discrimination influence the health outcomes of Africans from their own perspective?
3. What coping strategies do they adopt in dealing with discrimination while accessing healthcare services?

4. Are Africans aware of racial discrimination as a violation of their human rights and institutions responsible for dealing with such violations and providing support, and if they can access institutions that can respond to human rights violations?

1.1 Structure of the thesis

The thesis consists of five chapters. Chapter one offers an introduction to the entire thesis. Chapter two covers the literature review and theoretical framework employed in the study. Specifically, this chapter shall look at immigration in Norway and its associated matters with health and discrimination in Norway. Literature on the right to non-discrimination, equality, and right to health shall also be discussed in this chapter. The chapter shall further discuss the development of human rights in Norway, racism and anti-racism in Norway and finally, end the chapter with the Critical Race Theory, the theoretical framework guiding the conduct of the study. Chapter three of the study comprises methods employed in the study, including research design, target population, sampling and sample size, data collection tools and analysis, the interview process, coding, ethical considerations, strengths and weaknesses. Chapter four of the study shall focus on findings from the data analysis and discussions based on literature. The findings shall be organized based on the study questions. Thus experiences and manifestations of racial discrimination while using healthcare services, influences of racial discrimination on health outcomes, coping strategies and knowledge of racial discrimination as a violation of human rights. Chapter five shall discuss conclusions from the study, recommendations and suggestions for further study.

CHAPTER TWO: LITERATURE REVIEW & THEORETICAL FRAMEWORK

2.1. Introduction

Unlike Norway, racial inequities in healthcare have been long-standing with well-documented literature in the United States of America for policy formulation and research purposes (Jackson & Williams, 2006). Many health disparity researchers from other countries, including Canada (Nestel, 2012), have drawn inspiration from the popular '*Unequal Treatment: Confronting Racial and Ethnic Inequalities in Health Care'* study conducted by the US Institute of Medicine of the National Academies. The report assessed racial and ethnic influence on a variety of health services. The study concluded that persistent racial and ethnic discrimination in American life has a significant influence on the clinical encounter and often directly results in increased morbidity and mortality for racialized patients (Institute of Medicine, 2003). Francis (2001, p.29) finds that the wide range of examples regarding racial inequities in health, including areas such as access to care, life expectancy, morbidity, mortality, health status, disease prevalence and incidence, among several other domains, are clear evidence of society's silent support of the notion of the 'existence of the hierarchies of human worth'. Even under conditions of equal access to healthcare, the fact that these outcomes are evident should be an issue of concern to a welfare country such as Norway, where attainment of social rights is a fundamental concern (Kjønstad, 1994).

This chapter shall provide an in-depth review of existing literature on racial discrimination within the scope of human rights, immigration and healthcare. Specifically, areas to be covered in this section include an operational definition of discrimination and the rights to non-discrimination, equal treatment and health within the context of the Universal Declaration of

Human Rights (UDHR). Further, the section shall thoroughly analyze the Critical Race theory, the theoretical framework underpinning the study.

2.1.1. History of Immigration in Norway

Norway's immigration began following the discovery of oil resources at the North Sea in the late 1960s. There have since been three phases of immigration flows into Norway. The first phase saw the migrant workers from mainly Pakistan, Morocco and Turkey in the late 1960s after oil discovery come to take over jobs that Norwegians saw as unattractive to take up. After almost fifteen years of free flow of migrant workers from all walks of life, the Norwegian authorities introduced a new migration-related policy in 1975 that stopped labour-related migration into Norway (Berge et al., 2010). The second phase of immigration from 1980-2000 was underpinned by the humanitarian obligation to assist refugees and asylum seekers. This period also saw many people, mostly family members of the earlier labour migrants entering Norway through the family reunification scheme. Countries from which people entered Norway during this phase were Somalia, Former Yugoslavia, Vietnam, Chile, Sri Lanka and Iraq. The third phase, which occurred in the 21st century, witnessed a change in immigration into Norway. This period saw another era of labour migrants, but this time around from European Union member countries such as Poland and the Balkan countries following its expansion to include such countries (ibid). Immigrants in Norway have a wide range of cultural, social, religious and ethnic differences.

According to Statistics Norway (2018), the 2018 population data shows that immigrants add up to 14% of the population in Norway compared to 6% at the beginning of the millennium. Among all the immigrant groups, Polish is by far the largest group comprising 13%. Outside the European Union, most immigrants living in Norway are from countries such as Somalia, Syria, Iraq, Eritrea, The Philippines, Pakistan, Thailand, Iran and Afghanistan (ibid). Immigration for

work purposes and family reunification has been the primary reasons for immigration, while a few immigrate to seek asylum or undertake further study (statistics Norway, 2018). Among this broader group of immigrants are people from sub-Saharan Africa (SSA). Countries in this region are noted for their low economic status, political instability and a hub for the world's worst human development and health indices (The United Nations, 2017).

2.1.2. Relationship between Migration and health

There is a complex relationship between migration and health. There are instances where the disease has been responsible for or served as a means to or other times resulted from migration (Gatrell & Elliot, 2009). Typical examples in the past have been the spread of the plague or Black Death disease where individuals fleeing from seaports inland, as that was the starting point of the disease, ended up spreading the infection unknowingly to other people inland. Again, the spread of tropical diseases like malaria and tuberculosis to the Europeans during the era of colonization (Show et al., 2002) have been documented. Recent transmissions as a result of migration have included the spread of HIV in situations where men have infected women upon arrival from work-related migrations as well the continuous transmission of tuberculosis from African and Asian migrants to Europe as issues that are still being dealt with (Lurie, 2006 & Rechel et al., 2011). It is important to note that irrespective of the type of migration, thus within or beyond borders, migration has a significant impact on the migrants' health, those they have left behind, and the host population (Gatrell & Elliot, 2009 and Show et al., 2002). Also, disease transmission through migration has not stopped countries from opening their borders as the number of migrants' increases globally.

Data from the International Organization for Migration (2019), 2020 world migration report reveals that the number of international migrants is estimated at 272 million globally, equivalent

to 3.5% of the world's population. It means that most of the world's populations (96.5%) reside in the countries they were born into. On the other hand, most of the world's population instead migrates internally, with an estimated number of 740 million. The IOM notes mainly that the increase in the number of international migrants has been evident both numerically and proportionally. This is worrying because the increase has been at a slightly faster rate than previously anticipated. While there have been several factors attributed to migration, the current report finds work, as seen in previous reports, has been the number one compelling reason to migrate either internally or beyond borders. Followed by work are family reunions and study purposes. The report notes that the migration processes among these groups of migrants do not pose fundamental challenges to the migrants and their host countries. On the contrary, people have to leave their homes and countries due to compelling reasons beyond their control and often require some assistance and support during the migration process. Among this group are refugees and internally displaced persons (Ibid).

As the growing number of global migrants keeps increasing, there is continuous research among academicians, organizations, expert groups to provide up to date information regarding alarming issues related to the health, human rights and cultural backgrounds of migrants. This concern about migrants led organizations such as the World Health Organization to release guiding principles for meeting the health needs of migrants through a public health approach. These principles aimed to ensure fair health services, safeguard migrants fundamental right to health, put life-saving measures regarding conflict or disaster-related migrants and proper psychological health associated with post-migration stress (IOM, 2010).

2.1.3. Discrimination as a determinant of migrants' health

The World Health Organization (WHO, 1946) defines good health as a "state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity". This definition comprises holistic health by viewing the physical aspect of health characterized by the functioning of body parts, cells, tissues and organs, and psychosocial health, which is most often neglected. Many factors shape an individual's health, termed as the 'determinants of health" (IOM, 2020). These determinants can be applied to migrants across the migration cycle. These determinants can be at the individual level or structural level. Individual determinants include age, gender, genetics, while structural level determinants include legal frameworks and societal behaviours towards migrants. The structural level factors can result in a wide range of inequalities, including access to healthcare services. Mainly, migrants are likely to experience racism, discrimination and social exclusion, influencing their use of healthcare services (ibid).

2.2. The Right to Non-discrimination, Equal Treatment and Health

Non-discrimination has a triple status in the United Nations human rights instruments: it is a general principle, an autonomous right and an accessory right:

General Principle: in the Universal Declaration of Human Rights (UDHR)[5], Equality (and non-discrimination subsumed in it) – 'equal and inalienable rights of 'all members of the human family – is a *general principle,* the recognition of which is the ‘foundation of freedom, justice and peace in the world'. 'Equal rights of men and women, in particular, are reaffirmed in the fifth recital. Article 1 then proclaims: 'All human beings are born free and equal in dignity and rights. Thus, article 1 can express both a general principle of the human rights framework and an accessory right to be equal regarding the enjoyment of rights.

[5] Universal Declaration of Human Rights, 10th December 1948, 217A (III)

Autonomous right: the first sentence of Article 7 UDHR reads: 'All are equal before the law and are entitled without any discrimination to equal protection of the law'. This provision enshrines an independent (autonomous, free-standing) right to non-discrimination with two discernible elements of its content; equality before the law and equal protection of the law.

Accessory right: article 2 UDHR provides a right to non-discrimination attaching to all other human rights recognized within UDHR. The article reads:

> Everyone is entitled to all the rights and freedoms outlined in this declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinions, national or social origin, property, birth or another status. Furthermore, no distinction shall be made based on the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.[6]

This provision introduces an accessory (subsidiary) right to non-discrimination, or, to be more precise, it creates as many separate accessory rights to non-discrimination as there are human rights recognized in UDHR (e.g. a right to non-discrimination in respect to the enjoyment of the right to life; a right to non-discrimination in respect to liberty and security of person, a right to non-discrimination in respect to freedom of expression).

Equal treatment and health are protected as rights by national and often international legislation. Each person is thus entitled to both the right to equal treatment and the right to health. These two rights are inextricably interwoven: the right to health can be violated by discriminatory rules or practices in healthcare, and this includes rules or practices which have an impact on classes of

[6] Universal Declaration of Human Rights (no.5) article 2

people who find themselves at the intersection of multiple factors of vulnerability such as sex, age, ethnicity and disability (European Union Agency for Fundamental Rights 2013, p.20). If a person feels that their right to health has been violated by some conduct which appears – subjectively, objectively or both – unfairly discriminatory, this person might want to have his or her right to health, rather than his or her right to equal treatment, legally enforced, or the latter in combination with the former (ibid).

Since the 1948 adoption of the Universal Declaration of Human Rights, international agreements and national law have embedded the concept of patients' rights in the human rights protection framework. The declaration recognizes the "inherent dignity" and the "equal and inalienable rights of all human family members". Together with the fundamental dignity and equality belonging to all human beings, these concepts of a person constitute the basis of the development of the notion of patients' rights. The EU and Council of Europe have, among others, adopted international agreements since 1948 to provide legal protection to the right to health and to develop patients' rights (ibid, p22).

The right to health care encompasses several elements. First, the right to access care and treatment concerns the right for every individual to access the health services that his or her health needs require (WHO, 1994). This couples up with the right to information, according to which "patients have the right to be fully informed about their health status, including the medical facts about their condition; about the proposed medical procedures, together with the potential risks and benefits of each procedure; about alternatives to the proposed procedures, including the effect of non-treatment; and the diagnosis, prognosis and progress of treatment" (ibid).

2.3. Human Rights Development in Norway

The government of Norway has the duty to protect the fundamental rights of every citizen residing in the Kingdom of Norway. Chapter E in the Constitution of Norway safeguards human rights and maintains a commitment dedicated to human rights. Norway was the second country that ratified the European Convention on Human Rights (Strand, 2014) and has so far ratified the following United Nations Human Rights Treaties:

1. *CAT - Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment*
2. *CAT-OP - Optional Protocol of the Convention against Torture*
3. *CCPR - International Covenant on Civil and Political Rights*
4. *CCPR-OP2-DP - Second Optional Protocol to the International Covenant on Civil and Political Rights aiming to the abolition of the death penalty*
5. *CED - Convention for the Protection of All Persons from Enforced Disappearance*
6. *CED, Art.32 - Interstate communication procedure under the International Convention for the Protection of All Persons from Enforced Disappearance*
7. *CEDAW - Convention on the Elimination of All Forms of Discrimination against Women*
8. *CERD - International Convention on the Elimination of All Forms of Racial Discrimination*
9. *CESCR - International Covenant on Economic, Social and Cultural Rights*
10. *CMW - International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*
11. *CRC - Convention on the Rights of the Child*
12. *CRC-OP-AC - Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict*
13. *CRC-OP-SC - Optional Protocol to the Convention on the Rights of the Child on the sale of children child prostitution and child pornography*
14. *CRPD - Convention on the Rights of Persons with Disabilities*

Source: OHCHR: UN Treaty Body Database[7]

Being a member of the Council of Europe, Norway also has a well-established regional system for promoting and protecting Human Rights. It has ratified regional conventions, including the European Convention on Human Rights (ECHR), the European Social Charter Framework and Convention for the Protection of National Minorities and the Convention on Action against Trafficking in Human Beings (Benelhocine, 2012).

On 21st May 1999, the Norwegian Parliament passed the Human Rights Act that elevated five fundamental human rights conventions to have a special status in Norwegian law (Strand, 2014). In 2008, specific legislative provisions were amended to implement treaty obligations like Section 174 of the Criminal Code for introducing torture as a criminal offence. In May 2014, the Norwegian Constitution was amended, and several human rights were added as a part of the bicentennial anniversary that strengthened the existing constitutionally formulated rights. The Chapter of the Constitution on human rights includes rights to liberty, privacy, equality, freedom of expression, a fair trial, movement, assembly, and rights related to work, environment, children and the Sami people. Under Article 92, all public bodies must safeguard and respect rights enshrined in the constitution and the treaties of human rights of Norway.[8]

As an egalitarian welfare state, Norway portrays itself as a country where every individual has the opportunity to excel irrespective of their background, ethnicity, sexual identity and gender. The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) and Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

[7] OHCHR: UN Treaty Body Database. Available at https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx. Accessed on 10.04.2021
[8] Article 92 of the Norway constitution. Available at https://lovdata.no/NLE/lov/1814-05-17/a92. Accessed on 10.04.2021

has been implemented in the Norwegian law under the 2018 Equality and Anti-Discrimination Act. Furthermore, to shore up or promote more significant knowledge about human rights, the government of Norway created a new national human rights institution in 2015. This Institution is taking initiatives to ensure that districts look into the hate crimes, hate speeches, and address the inequality in treatment and utilization of healthcare services (Norum & Nieder, 2012).

2.4. Racism and anti-racism in Norway

2.4.1. Racism in Norway

Norway started experiencing immigration from the 1960s and thus still adjusting to the phenomenon of multiculturalism and racism. The past five decades have seen significant growth in the number of immigrant populations in Norway. According to the SSB (2018), about 14% of the Norwegian population is now immigrants or Norwegian-born children of immigrants. About half of these have African, Asian or Latin American backgrounds (Kyillinstad, 2017). The multi-ethnicity in Norway is causing social tensions and political controversy (Kyillinstad, 2017). Close monitoring of the media in the country reveals that policies and debates on immigration are often heated and polarized among the citizenry. Kyllinstad (2017) finds that the Norwegian public landscape is deeply involved with discussions about racism, discrimination, ethnicity, national identity, cultural pluralism, religious differences. These issues are, however, not constructed as racial issues in Norway. 'Race' has been removed as a concept in the official language, legislation, and constitution. This is to do away with adverse history (NOU, 2002, P.12). Instead, race is often replaced by skin colour or ethnicity. Gullestad (2002) suggests that the use of the term «immigrant» in Norway has become a "stigmatized way of labelling *them*". In this manner, it can be deduced to the extent that it functions similarly to racial labelling. Espeland & Rogstad (2013) suggests that one explanation can be found in the national narrative,

which depicts Norway as a small, innocent country that espouses universalism, equality and welfare. Another is that discrimination is a less *sensitive* term than racism—it does not resonate with racial theories, slavery and National Socialism—and is, therefore, easier to discuss.

Using the concept of 'identity, researchers like Gullestad (2002, s.46) have analyzed how people with immigrants or minority backgrounds never achieve 'true Norwegian' status. He suggests that for immigrants with a non-western background to be accepted as Norwegians, they would have had to forgo their cultural heritage and ultimately embrace the 'Norwegian way of life' (ibid). Turausky (2011, s.7) suggests that this concept of a common way of life might be part of the wider concept of '*Janteloven'* in Scandinavia. '*Janteloven*', which means 'the law of Jante', is an undocumented rule that suggests that no one is "innately superior or has greater moral worth than anyone else" and relates to "intellectual ability, physical appearance general ambition". While this cultural code enhances democracy within Scandinavian societies, it is arguably difficult to make room for a multicultural society. According to Gullestad (2002), this subtle cultural code has to a large extent been an existential problem for the Sami as well as people of colour who have to strive hard at being good Norwegian citizens. A survey conducted by the Norwegian statistical central bureau in 2013 revealed findings to support this argument. The study found that 49% of Norwegians supported the argument that "immigrants should strive towards being as similar to Norwegians as possible" (SSB, 2013). The SSB specifically referred to immigrants from Eastern Europe, Asia (including Turkey), Africa and South and Central America. It is clear in Norway that the word 'immigrant' does not refer to merely 'all immigrants' but rather specifically people with a non-western '*look*'. Gullestad (2004, s. 189) suggests that 9 out of 10 majority Norwegians refer to people with "dark skin colour" when they use the word "immigrant".

After a long silence of state authority on the existence of racism in an otherwise egalitarian state, public officials, including the prime minister of Norway, have publicly admitted to racism in Norway. This came in the wake of the black lives movement demonstrations that attracted tens of thousands of ethnic Norwegians and Norwegians with immigrant backgrounds, news stories and individual accounts of discrimination and racism in Norway. The government led by the prime minister had hitherto been silent following several criticisms over police brutality in the US against George Floyd. However, in her public address on the matter, the prime minister stated that "after the police violence that led to George Floyd's tragic death, racism and discrimination are unfortunately high on the agenda again". "Racism is not only a social problem in the USA," Solberg said, reminding how her government already has tried to address racism and discrimination in Norway. "This is an acknowledgement that it is also a problem in our own country." [9]

The online media platform further reported that while the prime minister admits racism and discrimination in Norway, many top politicians, especially from the conservative progress party, which has been known for its anti-immigration policies, are quick to dismiss its existence. For example, a top parliamentary member for the party who had earlier served as justice minister openly wrote on social media that he had "zero respect" for his thousands of fellow Norwegians who were out demonstrating "against a racism that does not exist in Norway."[10] Even worsening the situation is when another top conservative MP who serves as the party's spokesman on

[9] https://www.newsinenglish.no/2020/06/25/norway-comes-to-grips-with-racism/ accessed on 09.08.2021
[10] https://www.newsinenglish.no/2020/06/25/norway-comes-to-grips-with-racism/ accessed on 09.08.2021

immigration issues backed these claims by denying the existence of 'systematic racism' in Norway. These comments were met with uproar from the Norwegian media space[11].

The public debate and media discussions about racism and discrimination following criticisms, demonstrations and admission by state actors of the existing problem have opened expressions of individual accounts and experiences from Norwegians with immigrant backgrounds or adopted from abroad. These open discussions resulted in a "Me-Too" movement. The movement is for non-white skin Norwegians or Norwegians without Norwegian-sounding names. According to the NewsinEnglish (n.d), the Norwegian newspaper *Dagsavisen* suggests that what is happening now in the renewed debate over racism and discrimination is a new confrontation with the experiences of Norwegians who have been and are subjected to ethnic profiling, trouble getting jobs despite high education or facing difficulties even renting an apartment. The worst examples involve verbal and physical abuse.

2.4.2 Some accounts and experiences of racism and discrimination in Norway

A non-ethnic Norwegian youth is far more likely to be stopped and questioned by police than an ethnic Norwegian youth. A young man of Somali background gave an account to *Dagsavisen*[12] as reported in the news in English media platform of how police in Oslo stopped him on the street in the capital known to be occupied mostly by immigrants. As a 15-year old boy, he was pushed against a wall and demanded to see his ID. The young man, now 23, is quoted as saying, "They were aggressive, and it came out of the blue'. "There was no clarification; they got my ID but were not convinced I was not the person they were looking for," based on his "brown" skin colour. "This happened in front of lots of other people and was quite traumatic,"

[11] https://www.newsinenglish.no/2020/06/25/norway-comes-to-grips-with-racism/ accessed on 09.08.2021

[12] https://www.newsinenglish.no/2020/06/25/norway-comes-to-grips-with-racism/ Accessed on 10.04.2021

A young woman who has been open about her identity shared her traumatic experience with the newspaper *Aftenposten*. Safia Ahmed, a Norwegian with a Somali background, works as a health secretary at the national hospital in Oslo called *Rikshospitalet.* She recalled how a patient screamed at her that all 'Muslims are terrorists' and went on to grab her hijab. That was not the first time the elderly white man had openly proclaimed discriminative expressions towards her. He had earlier loudly proclaimed while other patients were around that "he hated hijabs and that people like me should not be allowed to work at a hospital," Safia told Aftenposten. He went on to ask her to leave Norway and 'go home' even though Norway is her home. This account of Safia led the Aftenposten to dig into other cases, including racism cases that have made it to court. The newspaper's findings revealed that Safia was far from being in this situation alone. Their investigations revealed that about 30 Norwegians had been convicted for racists' acts since 2015. The average age of those charged was 50; two-thirds are men, and nearly half the cases were based on skin colour, while nearly as many were directed against Muslims[13].

2.4.3. Anti-racism movements in Norway

The wave of the Black Lives Matter movement following the murder of George Floyd in the USA spread across the world. As a result, the topics of racism and racial discrimination have seen a surge in the Norwegian media landscape. As a result, more attention has been given to people of colour with immigrant backgrounds than ever before. Contrary to the subtle sidelining of racism in Norway, there have been open protests against racism this time. It is not only minority groups with immigrant backgrounds but with massive support from Norwegians with Majority backgrounds.

[13] https://www.newsinenglish.no/2020/06/25/norway-comes-to-grips-with-racism/ Accessed on 10.04.2021

Norway has had its fair share of similar antiracist movements before the black lives movement. Anti-racism in Norway started around the 70s after the Second World War. This was when Norway recorded a significantly higher number of immigrants (Nydal, 2007). Prominent among happenings that led to such movements is the death of Eugene Obiora, which occurred while police tried to arrest him (Espeland & Rogstad, 2012). The death of Eugene Obiora (40), a coloured Norwegian of African descent, occurred due to Police Brutality in Trondheim. Obiora was a jobless father who had visited his local social welfare office (NAV) to get money for food and a gift for his son's birthday. He refused to leave the office after his request was turned down.

The police were invited to help get rid of him. Three policemen, in an attempt to get him off the premises, wrestled him to the floor. While on the floor, one of the three policemen held his neck in a tight grip. Obiora died in the hands of the police while being held by some at his back and another pressing his neck tightly against the floor (ibid). Espland and Rogstad (2012) found in their study following this incident that concerns of the African community, particularly the Nigerians in Trondheim, turned into anger. The police service showed no seriousness in handling the situation as some of the officers involved in the case and was well known for their brutal behaviour towards immigrants, and minority communities were still patrolling the streets. They feared for their safety in the hands of these officers. Following Obiora's death, already existing antiracist groups, organizations and individuals seized the opportunity to form an *ad hoc* movement called *respect*. Through demonstrations, internet blogs (photos and videos) and rap music, the movement was able to frame and promote injustice. The movement drew attention and public sympathy by 'playing on emotional heartstrings' (ibid).

2.5. Theoretical Framework

This study derives its motivation from the Critical Race Theory. The difference in disparities of access to healthcare between minority groups compared to majority populations has grown out of historic and contemporary portions (Smedley et al. 2003, p.1). The already complex nature of healthcare characterized by health systems, administrative and bureaucratic processes, and the constant interaction between healthcare providers and patients weave together to create a complex matrix that contributes to inequalities in treatment for minorities in the United States (ibid). Apart from the interaction between the health system, health care providers, and patients, the complex matrix created also includes social factors such as racial and ethnic discrimination, language and cultural barriers, and socioeconomic status also affect the quality of healthcare (ibid).

Though predominantly used in the United States to analyze racial and ethnic disparities across several disciplines, including law and social science, the critical race theory has been adopted elsewhere to analyze issues related to racial and ethnic disparities, such as the Canadian Colour Coded Healthcare study that assessed the 'impact of Race and Racism on Canadians' Health' (Nestel, 2012). Therefore, this study shall draw on similar inspirations to analyze experiences of racial discrimination while accessing health care services within the Norwegian context.

The meaning of race is constantly changing, resulting in many controversies surrounding its usage (Omi and Winant, 2004). Regardless of the controversies surrounding race, this study will rely on the race concept with the goal of 'illuminating the much-contested nature of race relations and the process of racial formation' (ibid). Nowadays, it is more common to replace race concepts with more friendly concepts such as ethnicity, nationality, or class. However, this study shall stick strictly to the race concept as any replacement will contradict the visibility, historical

legacy of race and the outcome of racial formations. Several critical race scholars have applied the concept of the race while exploring the lived experiences of racial minorities (Hylton, 2009). Alcoff (2006) suggests that 'focusing on the lived experiences gives room to interrogate race not as a biological fact or an essential component of identity but rather as a historically constituted and culturally dependent social practice'.

2.5.1 Critical Race Theory

The critical race theory (CRT) originated in the 1970s when activists, lawyers and legal academicians across the USA realized that advances of the civil rights era of the 1960s had stalled, and racism was re-gaining grounds in a subtle manner. Realizing that new strategies, including theorizing, was necessary to combat this subtle comeback, early writers such as Derrick Bell and his colleagues, Allan Freeman and Richard Delgado took up the task (Delgado & Stefancic, 2011, p.3). CRT owes an outstanding debt to critical legal studies and radical feminism as it built on the insights of these earlier movements. It also draws inspiration from certain European philosophers and theorists such as Antonio Gramsci, Michel Foucault, and Jacques Derrida and the American radical tradition exemplified by such figures as Sojourner Truth, Frederick Douglas, W.E.B. Du Bois, Cesar Chavez, Martin Luther King Jr., and the Black Power and Chicano movements of the sixties and early seventies (ibid, p.4). Because the root of CRT is civil rights activism, it considers many of the same issues that conventional civil rights and ethnic studies discourses take up but places them in broader perspectives that includes economics, history, context, group and self-interest and even feel the unconscious. Unlike traditional civil rights, which stresses incrementalism and step-by-step progress, CRT questions the very foundations of the liberal order, including equality theory, legal reasoning, Enlightenment rationalism and neutral principles of constitutional law (ibid, p.6). CRT has now

grown to be an expansive and credible movement within and across disciplines, including healthcare. Hicken et al. (2018) thus suggest that researchers studying racial health inequalities should use a critical race lens when developing their framework and conceptual and analytic models. Critical race theory (CRT) developed in law studies is a constellation of principles that form an approach to the interpretation of structural factors, and more recently, to the scientific inquiry of racial inequities, including health inequities (Ford & Airhihenbuwa, 2010).

Critical race theory (CRT) is an interdisciplinary theory that provides a framework for studying the experiences of racially marginalized populations. Though developed by US scholars, the application of the theory has extended to other parts of the world (Warmington, 2012). Three central tenets characterize the CRT. This tenet helps in understanding and applying CRT, as discussed by Delgado et al. (2017).

Essential among the tenets in CRT is its function to criticize the idea that racism is ordinary. Delgado et al. (2017, p.8) explain explicitly that 'this notion of the ordinariness and normality of racism in the society advances the "colour-blind, or 'formal', conceptions of equality, expressed in rules that insist only on treatment that is the same across the board, can thus remedy the most extreme forms of discrimination". In other words, people of colour are indiscriminately ignored when developing social policies simply because an individual (white) person 'does not see race' and therefore 'is not racist' (Wesp et al., 2018, p.321). Beyond the non-consideration of people of colour in developing social policies that underserve them, they are also discriminated against, given that the hallmark of what is 'good' only resides in whiteness

Secondly, critical race theory critiques 'interest convergence' and material accumulation of wealth as a core manifestation of racism, primarily serving whites in the US society (Delgado et

al., 2017, p.8). Ladson-Billings & Tate (2006, p.11-31) indicate that whiteness is positioned as a property of interest in this regard. CRT thus contests the hegemonic functioning of social institutions that further the interests of Whites, materially and otherwise.

Thirdly, CRT upholds the fact that race is socially constructed. The 'social construction' thesis holds that race and races are products of social thought and relations. Not objective, inherent, or fixed, they correspond to no biological or genetic reality; instead, races are categories that society invents, manipulates, or retires when convenient. Racism from this perspective is thus a normal feature of society and is entrenched within systems and institutions such as the legal system, the educational system, the health system that continuously reproduce racial inequality. This assertion dismisses the thinking that racist incidents are aberrations but are manifestations of structural and systemic racism. People with common origins share certain physical traits, such as skin colour, physique, and hair texture. Nevertheless, these constitute only a tiny portion of their genetic endowment and are dwarfed by what we have in common and have little or nothing to do with distinctly human, high-order traits, such as personality, intelligence, and moral behaviour. However, society frequently chooses to ignore these scientific truths, creates races, and endows them with pseudo-permanent characteristics are of great interest to critical race theory (Delgado et al., 2017, p. 9).

CRT, in its usage, attends to issues of racism, which are believed to be ingrained in social institutions in Norway, especially in the Health sector. According to Hylton (2012), the scope of CRT identifies racial injustices among ethnic minorities and unveils the impact of social, political, and philosophical structures in advancing different forms of marginalization and injustices toward members of minority racial groups. Consequently, CRT allows for a holistic view of racial discrimination as it manifests systemically, leading to inequities in various sectors

of society, including healthcare. Mkandawire-Valhmu (2018, p. 50) states that the CRT "guides us in acknowledging the reality of inequality among these racialized groups and the racist ideology that informs healthcare interactions in our society". The theory provides healthcare scholars with a unique outlook for appreciating the causes of racism in the healthcare system as ingrained in "standard practices and structures" (Ford & Airhihenbuwa, 2010).

CRT further offers an opportunity for systemic structures that disfavour racial minorities and, in turn, promote racism to be highlighted and brought to the fore. Scholars have used CRT to explore the healthcare experiences of racial minorities like Hispanics and African Americans (Vardeman-Winter, 2017). An example of such a study is one conducted by Freeman et al. (2017) that found that systemic racism persists with institutionalized healthcare practices that do not consider the interests of minority groups. Minority groups experienced a lack of individual-centred care and reported being treated based on theory and numbers without adjusting to suit their situations. These practices that propagate racist ideologies often result in a profound loss of interest, distrust of healthcare providers and unacceptance of healthcare practices. While studies like this and others have used the CRT to unravel how structural racism influences the experiences of ethnic minority groups in the usage of healthcare services in the US, there is a paucity of research that uses a similar approach to analyze racial disparities within the context of the Norwegian healthcare system.

The employment of CRT in this study shall thus offer the researcher a guiding framework to critically analyze the interrelation of racial discrimination and the healthcare usage experiences of Africans living in Norway.

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This chapter aims to discuss the methods employed in this study to collect and analyze data. The methodology is a vital component of the entire research process as it influences the validity of the research findings. The study design, sampling, data collection and analysis are discussed in this chapter. Further, the chapter discusses the characteristics of the study participants, details of the interviews, coding, reliability, trustworthiness, ethical considerations and challenges encountered in the research.

3.1. Research Design

The study employed a qualitative research design. This approach was used to explore the racial discrimination experiences of Africans living in Norway. Specifically, the study explored racial discrimination manifestations, influences on health service use and health outcomes, coping strategies and awareness of human rights among Africans living in the capital of Norway. A case study approach was further employed in this research design. This was to enable the researcher to obtain a profound overview of the study. A case study design involves an extensive and intensive analysis of a specific case (Bryman, 2016). According to Zainal (2007, p2),

Researchers use individual encounters to draw meaning about complex phenomena. Zainal explains case studies further by stating that it 'explores and investigates contemporary real-life phenomenon through detailed contextual analysis of a limited number of events or conditions, and their relationships (ibid). There are different dimensions of case studies, including exploratory case studies. The study thus specifically employed exploratory case studies in order to elicit appropriate data. 'Exploratory case study design explores any phenomenon in the data

which serves as a point of interest to the researcher' (Yin, 1984). It helped the researcher to conduct an in-depth, thorough and critical evaluation of the research.

3.2. Sampling design

The present study used the non-probability sampling technique. Specifically, purposive and snowball sampling techniques were used to recruit study participants. In purposive sampling, researchers do not employ random methods to select study participants but rather recruit participants based on their characteristics, which is relevant to the research (Bryman, 2016). Using this sampling technique, the study selected only Africans from African countries living in Norway for the study. Snowball sampling technique, on the other hand, is a convenient sampling technique, which involves a researcher making initial contact with a participant with desired characteristics and the participant further referring or leading the researcher to other known people with similar characteristics that are relevant for the study (Bryman, 2016). Since the study involved Africans from all over Africa other than Ghana, where I come from, I had to rely on the first participants I had contact with to lead me to other Africans. Ghanaian participants were easy to reach as the researcher live in an area with most of them. The researcher, however, had to reach out, schedule appointments and travel to other parts of the city to meet participants from other African countries.

3.3. Data collection and analysis

Primary and secondary data were used in order to obtain relevant data for analysis in this study. The Primary data consisted of data solicited directly from the study participants through the interviews. In contrast, the secondary data sources consisted of books, online journals, reports, news articles/media sources, government publications, and publications from international organizations such as the United Nations Human rights council.

In soliciting data from participants, the researcher used the semi-structured interview guide. This data collection tool provided an opportunity for open-ended questions allowing for further probing and clarifications (Bryman, 2016). Semi-structured interviews are commonly employed in qualitative studies. A guide directs a researcher on topics and areas to ask questions during the interview process. This tool is flexible as relevant topics identified during the interview can be taken on and delved into, which further enriches the research findings (Bryman, 2016). Biodata listed on the interview guide included age, gender, marital status, number of years living in Norway. The main guiding questions were based on the research questions.

3.4 Participants

Study participants were adult African migrant men and women living in Oslo; Migrants and persons with legal residence, above 18 years of age, and willing to participate were included in the study. A sample size of 15 African migrants willing to share their experiences about racial discrimination regarding healthcare service use was invited to participate in the study. Participants were mainly from Ghana, Nigeria, Cameroon, Uganda and Gambia. These participants lived in Oslo, the capital city of Norway. Oslo is the largest city in Norway, and it is both a municipality and a county. Oslo is the administrative and economic hub of Norway. It is also a centre for trade, industry, and shipping. Oslo is an international city rated first in terms of quality of life among other cities in Europe, but it is also one of the most expensive cities in the world. According to the statistics bureau, immigrants make up about 33.1% of the total population in Oslo (Statistics Norway, 2018).

3.5. Interviews

Due to the Covid-19 pandemic and subsequent lockdown of Oslo, all fifteen interviews were conducted over the telephone. The recording app in the mobile phone was used to record all the

interviews following the consent of the participants at the start of the interview. The interviews were conducted based on the availability and schedules of the participants and lasted on averagely for an hour. Interviews were conducted in English as all the participants understood and spoke fluent English.

3.6. Coding

Bryman (2016, p.13) defines coding as a process whereby the data are broken down into their parts, and those parts are then given labels'. This process plays a significant role in classifying themes from the interview transcript. The researcher initially generated a coding scheme following a consecutive review of the interview transcripts. With the initial coding scheme at hand, the researcher then coded the second set of transcripts and kept revising the theme until no new theme was identified. As significant and interconnected codes were brought together based on their relevance, irrelevant codes were dropped. Relevant and interconnected were, after that, congregated into each theme.

3.7. Reliability and trustworthy

These two factors must be taken into consideration by researchers when designing a qualitative study, analyzing results, and judging the quality of the qualitative study and these factors help to reveal the credibility of the research (Golafshani, 2003). Bryman (2016) adds that these two factors are often based on an individual's determination to ensure trustworthiness, as it is significant in qualitative research. Though these two factors have separate meanings in quantitative research, qualitative research embodies them into one phenomenon measured by its credibility, transferability, dependability, and confirmability (Golafshani, 2003 and Bryman, 2016). With this background knowledge, the researcher ensured that trustworthiness was a guiding principle in the conduct of the research. The study results are thus generalizable into the

general population as consciousness about the trustworthiness of the study resulted in a quality research output (Golafshani, 2003).

3.8. Ethical considerations

Before starting the actual research work, the reseacher submitted the project proposal, an information letter outlining how the study will be carried out and a sample of the informed consent form to the Norwegian Center for Research Data (NSD) for ethical approval. The approval was obtained that before commencing the research. During the research, participants were given adequate information about the purpose of the study and invited to be part of this research. Participants were not coerced to decide to participate in the study as it was voluntary. Verbal consent was obtained after they agreed to participate in the study. Participants were informed that they could change their minds later and stop participating in the study even though they had agreed earlier. Participants were asked to share some very personal and confidential information with me, but they were informed they did not have to answer any questions if they felt they did not want to. They did not have to give any reason for not responding to any question or refusing to participate in the interview. The researcher ensured the participants that he shall not share information about them with anyone to ensure confidentiality and privacy. The information that the researcher collected from this research project was kept private. Any information about participants had numbers on it instead of their names. Only the researcher will know what their number is. After analyzing the data, the researcher made sure all the interview recordings on my mobile phone were deleted to prevent third party access. No participant was harmed in any way before, during and after the conduct of the research.

3.9. Strengths and challenges

The covid-19 pandemic that resulted in lockdowns and social distancing affected the conduct of the research work. The pandemic posed a significant challenge for face to face interviews as part of the data collection process. People are more naturally used to face-to-face interviews without distraction than telephone interviews, where calls come through in the interview. Again not everyone is used to long telephone conversations lasting for about one hour. Because the pandemic had shifted most work to operate from home, potential participants complained of not having time as they worked any time of the day to ensure their assignments were accomplished. The researcher had to follow their schedule for participants who agreed to participate, even if it was inconvenient.

Because the researcher speaks British English and 'African English' called 'pidgin', a form of English common among Africans, it was easy to create a quick rapport with especially the male participants. However, the language was not a hindrance in the conduct of the work.

There was also a challenge with accessing books for the literature part of the research. Libraries had been closed down due to the pandemic. I, therefore, had to rely mostly on online journals for relevant articles.

3.10 Positionality

Racism and discrimination is not a new concept to me. However, it might perhaps seem different from where I come from, Ghana. Discrimination is based on tribe other than Race in Ghana, so the term 'tribalism' is expected in the Ghanaian literature. This form of discrimination occurs in several forms, for example, seeking employment, accessing healthcare services, government

budgetary allocation, among several others. It seems to have become normal such that it has earned the nickname 'whom you know.

I think that in contrast to racial discrimination in advanced countries such as Germany, Russia, the USA, the forms expressed in Ghana are without 'hurt' or hateful expressions. Before migrating to Norway to study, I had not heard about overt discrimination in Norway. I had only read that Norwegians are generally 'cold' and reserved. My motivation to research this topic stems from my personal experiences with the Norwegian healthcare system. As a health professional, I know specific investigations cannot be carried out on a patient without their consent. A doctor added a test to a series of mandatory laboratory tests I was to take as a new arrival in Norway. I had read the necessary documents and knew the information to be collected, which in any case, the doctor was obliged to inform and seek my consent. I felt discriminated against because of my colour. The doctor assumed that I had certain diseases common in Africa and must therefore screen for them. Beyond the healthcare setting, I worked for UNICEF Norway as a street ambassador, raising funds for UNICEF's projects. One broad daylight in the middle of Karl Johans street, one of the busy streets in the centre of Oslo, an unknown ‘whiteman’ spat a mouthful of saliva on my face while I engaged two potential donors. My colleague who stood about 100 metres away from me on the same street also suffered the same fate from the same person. After my human rights course and exposure to the field, I decided to explore further to find out the actual situation among Africans living in Oslo. Despite my personal experience with racial discrimination in Norway, I ensured this experience did not influence the research process. Beyond my personal experience, I have been exposed to different ways other Africans are experiencing discrimination.

CHAPTER FOUR: FINDINGS AND DISCUSSIONS

This chapter shall discuss the findings from the study. The chapter is divided into two main sections; Results and Discussions. Under each of these main sections, the content is further organized to capture the four objectives of the study. These objectives include experiences and manifestations of racial discrimination when using healthcare services in Norway and influence on health outcomes and health service use among the participants. The third objective focuses on coping strategies among participants when they experience racial discrimination and, finally, the knowledge of participants about existing human rights laws and institutions that serves their interest.

4.1. Results

4.1.1 Background characteristics of study participants

The study involved Fifteen Africans who live in Oslo. Out of the Fifteen participants, four were from Ghana, three from Nigeria, three from Cameroon, three from Uganda and two from Gambia. There were four males and ten females. Participants' age ranged from 25 to 45 years. Four of the participants were single without any children, while the remaining eleven were married with children except one participant. All participants have lived in Norway for three or more years, with the highest being sixteen years. All Fifteen participants have education regarding education, including primary education, senior secondary education, and university education. Fifteen of the participants who came to Norway as students have a Master degree. Participants who came on the family reunion route have a master degree (1), bachelor degree (4), senior secondary education (3), vocational education (1), and Basic education (1). Nine of the participants came to Norway purposely to join their families on the family immigration visa. Five came as students on the student visa, and one came as a worker on the workers' visa.

Healthcare services that participants have used include the family doctor, the hospital and emergency services. All Fifteen participants have used the services of the family doctor. Participants with families, including children, have used all three services more than five times throughout their stay in Norway. All participants have used healthcare services two or more times.

Concerning racial discrimination, ten participants have been racially discriminated against while using any healthcare services in Norway. The remaining five participants have not been racially discriminated against while using any of these services. Among the ten participants who have experienced racial discrimination. This data is presented in Table 4.1 below as shown below:

Table 4.1: Background Characteristics of Study Participants

No.	Nationality	Gender	Age	Marital status	No. of children	No. of years living in Norway	Education	Purpose of coming to Norway	Healthcare services used	Number of interactions with the health system	Experienced racism
1	Ghana- Ali	Female	30	Married	2	4	Senior Secondary school	Family reunion	Family doctor, hospital, emergency services	>5	No
2	Ghana-Ama	Female	25	Single	0	16	Bachelor degree	Family reunion	Family doctor and hospital	>5	Yes
3	Ghana- Adwoa	Female	32	Married	1	5	Vocational school	Family reunion	Family doctor and hospital	>5	No
4	Ghana-Kwasi	Male	36	Married	3	3	Master degree	Studies	Family doctor, hospital, emergency services	>5	Yes
5	Nigeria-Oju	Female	30	Married	0	3	Bachelor degree	Family reunion	Family doctor	3	Yes
6	Nigeria-Ada	Female	33	Married	2	6	Master degree	Family reunion	Family doctor, hospital, emergency services	>5	Yes
7	Nigeria-Ebe Ano	Female	32	Single	0	4	Master degree	Studies	Family doctor and hospital	2	Yes
8	Cameroon-Divine	Male	27	Single	0	3	Master degree	Studies	Family doctor	3	Yes
9	Cameroon-Philip	Male	35	Married	3	5	Master degree	Studies	Family doctor, hospital, emergency services	>5	Yes
10	Cameroon-Ogah	Male	28	Married	1	4	Senior Secondary	Family reunion	Family doctor, hospital, emergency services	>5	No
11	Uganda-Rose	Female	32	Single	0	4	Master degree	Studies	Family doctor	3	Yes
12	Uganda-Juliet	Female	40	Married	3	15	Basic Education	Family reunion	Family doctor, hospital, emergency services	>5	No
13	Uganda-Rob	Male	45	Married	4	10	Bachelor degree	Work	Family doctor, hospital, emergency services	>5	Yes
14	Gambia- Yube	Female	31	Married	1	4	Senior Secondary	Family reunion	Family doctor, hospital, emergency services	>5	No
15	Gambia-Ogene	Female	33	Married	2	5	Bachelor Degree	Family reunion	Family doctor, hospital, emergency services	>5	Yes

Source: Field data, 2021

4.1.2. Results of racially discriminated participants

This section presents the results of the ten participants who reported that they had experienced racial discrimination while using healthcare services.

4.1.2.1 Experiences and the manifestation of Healthcare racial discrimination

When participants were asked about how the discrimination was expressed or manifested, three sub-themes were identified; facial and body expressions, language problems and lack of trust.

Facial expression and body language: a non-verbal way of communication is the use of facial expression and body language. These communication forms can send signals of welcoming, warmth, interest and readiness. In the same way, it can tell when a person is not welcome or disgusting or unwilling to be of help. This sub-theme was reported by the majority of participants as the way healthcare workers discriminated against them. Ama, a 25-year-old single woman from Ghana who has lived in Norway for sixteen years and understands the Norwegian work culture and, as a Nurse herself, knows when a non-verbal expression is a discriminatory act. She recounted her experience when a temporary doctor subjected her to racial discrimination, as: *she expressed it by her facial expression and body language. Prior to going to the health facility, my Norwegian friends who had used her services indicated she was very nice and treated people well, so I was expecting a similar treatment only to have a bad experience. The way she looked disgusted at me upon seeing me was very bad. It was as if I was some sort of trash, which she did not want to see. I am a nurse and I know how healthcare workers welcome patients with handshake is if possible, smiles and make them feel at home. This is exactly the opposite of that.* This was not the first time she was using healthcare services in Norway. She could identify the difference in the care she had received in the past and when racial discrimination occurred. When asked why she thought she was a subject of racial discrimination, Ama was quick to say: *the*

temporary doctor was Polish. Eastern Europeans, especially Polish, hate Africans and are racist towards us.

Similarly, a 30-year-old Nigerian woman, Oju, who has lived in Norway for three years, had gone to see her family doctor for the first time after arriving in Norway. Prior to attending the consultation, she had heard and read about how the Norwegian healthcare system is one of the best in the world. Truly, while waiting to meet the doctor, she observed the warm and lovely manner healthcare workers welcomed patients and lead them to the consulting room. She admits that even though she did not understand what the healthcare workers said to patients during their initial contact, she was convinced by the body language of the workers that they were happy to see them. It, however, turned out to be different when it was her turn to be met and ushered into the consulting room. In her words: *while waiting for my turn, I observed how the doctors came out smiling to welcome and lead patients to the consulting room. It was very impressive. Though I did not understand what they said to patients while welcoming them, the smiles on their faces made me feel at ease. But when it got to my turn, I didn't get the same treatment I had observed. The body language and facial expression were kind of a hasty one. There were no pleasantries. The whole consultation went very fast, and there was no physical examination to ascertain my complaints.* This encounter left Oju confused. Probing to find out what Oju thought could have led to such sudden change on the part of the healthcare worker, she said: *In fact, I don't know, but I think maybe because I am black. People have a lot of negative notions about we black people. They know that we have many and strange diseases which they might not be familiar with.*

Non-verbal communication goes beyond facial expression and body language in the healthcare sector. 36-year-old Kwasi from Ghana who came to Norway as a student recalled how his second

form racial discrimination was experienced after living in Norway for three years. It was not his first time of having his blood sample taken, but it was his first time at the hospital after his family doctor had requested for some specialized laboratory test. Kwasi report that healthcare workers do not wear gloves while taking his blood sample or that of his family anytime he accompany them to the family doctor's office. To his utmost surprise on that day, the healthcare worker at the hospital did not only wear one pair of gloves but two pair right in front of him. He puts it this way: *The second time happened when my doctor had referred me to the hospital for specialist services. The healthcare worker at the laboratory section for blood sample collection point wore two sets of gloves right in front of me in order to take my blood sample. This was not the first time I had had my blood sample taken, and they actually do not wear gloves, but I was surprised to see this person wear two gloves.* Kwasi narrates how it was devastating. When asked why he thought he suffered that treatment from the healthcare worker he responded: *I don't know why the healthcare worker wore two gloves. Her reason is best known to her. But I thought perhaps she didn't want to have physical contact with my skin. I also became worried that perhaps I have a dangerous infection which my doctor did not mention to me. I mean the thoughts were just too many.*

Language issues are further identified as a sub-theme under forms racial manifests in the healthcare sector. The official language spoken and written in Norway is Norwegian. But unlike many minority languages, the English language has benefited from some written translations at some public spaces, especially in the transport and tourism sectors that welcome millions of tourists to Norway each year. The healthcare sector has however not benefited from many translations from Norwegian to English as is the case in the transport and tourism sectors. Due to the sensitive and critical nature of health, communication challenges could have fatal

consequences for patients. All participants in the study could speak and write English fluently. Others could read and write Norwegian fluently as well. Non-Norwegian competent Africans in this study reported how they perceived the system to be working against them. Ada, a 33 year old married Nigerian woman recounts she how went through an ordeal at the maternity unit of a hospital while on admission to deliver her baby. Her husband who is Norwegian competent had always accompanied her to check-ups and did most of the interpretation, so she did not realize the magnitude of the situation until she was alone at the maternity unit. Narrating her ordeal: *It was my first time giving birth at the hospital. All the writing and information available was in only Norwegian and I did not understand anything that was being said. I was shocked considering that Oslo is a multicultural city, at least versions of other languages like English will be available. The midwives tried explaining procedures in English instead of a certified translator, which I did not really understand but had to just cope. When I say cope, I mean I was in so much pain such that I responded yes to whatever they were saying. It was frustrating and I just wanted my baby delivered for me.* Ada, however, did not think it was the fault of the healthcare workers that there was a challenge in communication. She puts it this way: *Well, I do not think the healthcare workers intentionally discriminated against me. I feel it is an institutional thing. Like the system sort of telling you are not welcome or you are not part of us and that if you want to stay with us integrate properly by learning Norwegian.*

Ada is not alone in this situation. Phillip, a 35 year old married man from Cameroon with three children who came to Norway on a student visa, had a more frustrating language barrier experience. He narrates how one of his children had an emergency illness and he had to rush the child to the emergency unit. It was his first time at the unit, and he had no idea where to start from upon arriving. Unlike his family doctors office where there is someone available to receive

patients, this environment was rather different and chaotic with many people. Announcements, signs and notices were all in Norwegian. He was very frustrated for a while before getting help. He had this to say: *It was such a huge and busy place. Information on posters, announcements, directions, leaflets and signs are all in Norwegian language. It was frustrating as I found it difficult to understand what was going on at the health facility and did not know the first point of call.* Philip feels the system does not consider the interest of Africans knowing very well it is not easy learning Norwegian and being competent within a short period of time. *I have lived here for five years. I spent three years studying (in) an English program. Two years is a short time to be fluent in Norwegian. The system should at least consider that there are minority groups like Africans who can at least speak English also make use of healthcare services.*

Other participants expressed their experience with language barrier as follows:

The nurse at the reception desk did not bother to ask which language I preferred to communicate with, but right away she began speaking Norwegian language. She assumed that I understood Norwegian because I am in Norway and expected to (Rose, 32, Uganda).

I did not speak good Norwegian, and the doctor was not good at English. We tried to communicate, but I felt we didn't understand each other. It was a hopeless situation (Ogene, 33, Gambia).

Information on posters, announcements, directions, leaflets and signs are all in Norwegian language. It felt as frustrating as I found it difficult to understand what was going on at the health facility (Ebe Ano, 32, Nigeria)

Another common sub-theme identified is the lack of belief in the medical complaints of Africans. Many of the participants reported how healthcare workers have in the past refused to

accept that they were actually in pain or sick and required serious attention. Thirty-six year old Kwasi narrates his ordeal as he once visited his family doctor during a severe back pain episode: *My family doctor subtly refused to write a sick leave for me after I explained to him that my work involves frequent standing and lifting and so some days off work would be helpful while I take the medications in order to fully recover. The doctor insisted that he does not just write sick leave for anyone and that he believed I could manage to work while on treatment. He joked about the fact that Africans are strong and so I should be equally strong. Even though we both laughed about it, I was actually in pain, but he did not believe me when I said the pain was severe.* When asked why he thought the doctor treated him that way*: because am black with muscles and look strong, he thought I could not be in pain. I think he didn't believe that I was actually going through pain and that it was just a ploy to take days off from work.*

4.2.2.2 Influence of racial discrimination on healthcare services and perceived health outcomes

All ten (10) participants who experienced racial discrimination indicated the experience to some extent influenced the services they received from the health facilities. Participants felt they did not receive adequate care as expected. Ama, 25 from Ghana reported how her expectation of 'superb' treatment based on her Norwegian friend's commendation of the doctor turned into a disaster when the doctor racially discriminated against her using body language and facial expression. She tells how she reacted back and ended up leaving the doctor's office without further consultation. *I got so emotional and angry that I told her I was no longer going to continue the consultation. I left afterwards without allowing her to attend to me.* While not all participants are bold like Ama to have reacted back quickly, I believe that deep within them, they felt they were not receiving appropriate care. This was very evident in situations where language

was a major challenge and situations where healthcare providers did not believe that participants were actually in the kind of pain they said they were in. 33-year-old Ada from Nigeria believed the language barrier at the maternity ward while on admission to deliver her baby resulted to her non-involvement in her care as is expected of caregivers. She said: *I could not disagree with procedures and just kept saying yes to all the midwives were saying. I know there are several childbirth alternatives like getting an epidural to reduce delivery pain, but I was not given an option to choose from. The delivery went well, though, but I still feel I should have been given the opportunity to participate in the decision making process.* Kwasi from Ghana felt the doctor's disbelief of his severe back pain and not willing to offer sick leave period for full recovery resulted in him not receiving adequate care. *I mean how can I recover when I am using the same pain to continue to work? The medicine alone without rest would not work. Without the sick leave I won't be paid for the days I would be away from work, and that would be difficult for me and the family.*

One would have thought that if racial discrimination influenced the healthcare services the participants received, then there could be chances that it could equally influence their general health outcomes. However, participants reported that the discriminatory episodes did not have an impact on their health outcomes. In the words of Ama: *I was lucky it was not an urgent health need. It was a routine check-up that I was attending, so I waited until my own personal doctor resumed duty after some weeks.* Severe back pain sufferer participant Kwasi said: *I had no option than to work while undergoing treatment because the doctor refused me the sick leave. I spoke with my supervisor at work about my plight. He was helpful by giving me non-strenuous assignments. This really helped me to recover within a short period.*

While some participants have continued to use healthcare services despite experiencing racial discrimination, others, especially single-unmarried participants have mostly resorted to other means. Participants with families and children continued to use healthcare services because, unlike single participants who could resort to self-medication, they could not risk the lives of children. Rob, a 45 year old man from Uganda who has four children said: *you know children are not like us adults. They often fall sick, especially in the winter and require that I accompany them to the family doctor. I just ignore these racial issues because of the children.* Another participant said*: Yes, I have continued to visit my family doctor. I waited until my permanent family doctor returned before I continued using the services of the family doctor. I have since continued to attend consultations when the need arises (Ama, Ghana). I have come to appreciate that it is not every time I experience discrimination when I attend the health facility. Because of that, I continue to use to it and have developed strategies for dealing with it when I experience it (Ebe Ano, 32, Nigeria).*

Self-medication is the measure for participants who reported avoiding the healthcare facility after experiencing racial discrimination. *Oh, I don't even waste my time to go to the health facility after I realized it was frustrating every time with language issues. I arranged for a friend to bring me common medications such as painkillers, antibiotics from Uganda. I manage myself anytime I feel I am not well. Once I take the medicines, I get back on my feet again.it saves me time and from been humiliated by these racists (Rose, 32, single, Uganda).* A male participant who would not want to be made to seem to be lying put it this way: *Me? Never again! Whites don't believe anything that comes from an African. This time I just go to the pharmacy to buy some painkillers. Luckily I don't have any sickness that require monitoring, I usually get tired*

and stressed from work resulting in general body pains and some occasional cold in the winter (Ogah, 28, Cameroon).

4.1.2.3 Coping strategies

Only one out of the ten participants who had experienced racial discrimination was able to confront the perpetrator of the discriminatory act. Ama, a 25 year old nurse trained in Norway did not let her guard when she was faced with the situation. She narrated her experience as: *I was so angry and spoke my peace of mind to the temporary doctor. I made her aware that I won't take it likely if the incidence happen again.* She continued: *that's how some whites are towards blacks, very racists. I have seen several racism events as a nurse in health facilities I have worked at. There have been times I have personally had to intervene on behalf of racial victims.* When asked about her awareness of how other Africans have responded in such discriminatory events, Ama said: *well, I know healthcare workers who are familiar with the work environment regarding rights and ethics do not allow perpetrators of racism to go free. I have also heard that most people who do not communicate in Norwegian or have health backgrounds just ignore them and move on.* When asked about how she thinks the Norwegian government can help prevent racial discrimination at health facilities, she responded saying: *Hmm, it is difficult for the government to stop discrimination. I think it is individualized because not all healthcare workers are racist. Racist in health facilities should receive severe punishment when caught.*

The remaining participants choose either to avoid creating a scene by not reacting back to instances of racial discrimination or tried to keep a friendly outlook in the light of a very unpleasant situation. A participant among this group shared his thoughts about how racial discrimination can be reduced as: *I don't blame them when they do that to us blacks. I blame the black leaders and what they have turned our societies into. These people see us living like*

animals, and it's all over the television and internet. How do we then want to be treated? Yes, we are humans, and it is painful to be discriminated against. Such is life when you live in another man's land. Other Africans I know who experienced racism just kept it themselves without reacting back. I don't think I can do anything to prevent others from experiencing what I experienced because I think a person who is racist will always be a racist. Maybe the government can give more attention to the prevention of racism at the health facilities by openly talking about it in the media (Divine, 27, Cameroon). Another participant had this to say*: I know I am black and I can't change my colour. Whites always look down on us and treat us differently. It is something that has become normal in society for them. I don't see the need to engage in any sort of confrontation, it's better to just ignore and live my life. As for issues of discrimination, I don't think it will ever come to an end. We are even lucky because there is no much racism here in Norway. I first studied in Russia before coming here hmmmm that place is worse (*Kwasi, 36, Ghana*).* A participant shared how angry she felt, but for fear of been denied proper care, she just ignored the situation and pretended as if it did not happen. *For fear of being denied proper treatment, I just keep quiet. I am angry within, but what can I do? The best way is to report such healthcare workers at the same time the discriminatory episode happens in the health facility. But whom do you report to? There is no channel to communicate your feelings and concerns to apart of a rating of services text message one receives after leaving the health facility. I doubt if the government can do anything. It's just a difficult situation.*

A participant who maintained a positive or friendly attitude when he felt discriminated indicated he did not want to ruin the relationship he had with the doctor because of his family's sake. He expressed himself as: *He can't do what he did to me to a white person. I felt discriminated against for him thinking that Blacks are strong people and so I could manage to work with my*

pain. We both laughed about it, but I was not happy within. I wanted to keep a good relationship because of the family and so ignored it (Philip, 35, Cameroon).

4.1.2.4 Awareness of racial discrimination as a violation of human rights and institutions responsible for dealing with such violations and providing support

All fifteen (15) participants responded that they knew discrimination to be a violation of one's human rights. The participants knew that all human beings are equal and hence should be treated equal irrespective of one's skin colour. They knew that all humans must be subject to equal treatment and that non-equality constitutes a violation of basic fundamental human rights. Ebe Ano from Nigeria put it this way: *I know that all humans are equal irrespective of where we come from and our skin colour. Racism and discrimination is a violation of our human rights*. Rose from Uganda puts it this way: *Oh yeah I know racial discrimination is a violation of one's human rights because all humans are equal. But hmmm are we really equal?* Probing further she says: *you know we Africans have been presented as and treated as animals. No wonder some whites look down upon us and disgusts us.* 33 year married woman, Ada from Nigeria agrees it is a violation of human rights to discriminate but thinks this applies to some group of people. *In theory, I know discrimination or racism is a violation of human rights, but I think this violation is not for everyone. I think it is rather a violation of white peoples right not us black people. What rights do we have? Nothing. They know blacks do not have that confidence to speak up, and so they look down upon us. I believe that all human beings were created equal and so we should treat each other as equals, and this is also in human rights documents,* says Oju, 30 year old married woman from Nigeria.

With regard to the institutions or organizations involved in advocating against discrimination/racism/prejudice in Norway, the study found that all 15 participants knew the existence of such organizations and institutions. Organizations and intuitions identified by

participants include the United Nations, the United Nations High Commissioner for Refugees (UNCHR), Integration and Diversity Directorate (IMDI), the Norwegian Human Rights Fund, Norwegian Centre for Human Rights, Human rights ombudsman, the Norwegian Directorate of Immigration (UDI) and various Labour organizations. Responses from some participants are shared below:

I know there are several organizations that work in this area. I am sure the racism and discrimination situation would have been worse if these institutions did not exist. They are doing their best, for example, the UDI and the United Nations. I also heard about a human rights court in Norway but I don't know much about that (Ada, Nigeria)

I took a human rights course at the Norwegian University of Life Sciences, and that exposed me to human rights and several measures that are been put in place to in place by organizations. For example, the human rights Ombud provides support for people who experience discrimination and racism. However I personally I feel it is a waste of time going to these institutions considering the bureaucratic processes that might be involved. It might even emotionally drain you. I have developed thick skin for racism and I think that is the best strategy for us Africans (Kwasi, Ghana)

As for the institutions, there are many of them around. They claim they are advocating against racism and discrimination, but it is happening every day. I mean we see it every day. With this black skin, it is difficult with everything including a decent job, accommodation etc etc. (Ogah, Cameroon).

I worked briefly with UNICEF here in Oslo for a while, and I know they are also involved in children rights, but I am not sure I remember a program focusing mainly on racism and discrimination. My labour union at work, LO, encourages us to report to the leadership when situations of racism and discrimination occurs (Rob, Uganda).

4.1.3 Results of not racially Discriminated participants

Out of the fifteen participants who were interviewed, five responded that they had not experienced racial discrimination while using any of the healthcare services in Norway. Two of these respondents were from Ghana, one from Cameroon, one from Uganda and one from Gambia. All of these participants have some form of education with Senior High/Vocational School as the highest. They have also lived in Norway for more than three years and have each used healthcare services, including family doctors, emergency services and hospital for more than five times since their stay in Norway.

The study had a different set of questions for this group of respondents. When asked about what kind of treatment they received or have been receiving that made them perceive or feel not discriminated against, these participants indicated they were always welcomed nicely, respected and the services they received were of high quality. They were further asked if language was not a barrier when using healthcare services and whether or not the healthcare workers had adequate knowledge about her condition if it was a tropical one. Interestingly language barrier did not seem to be a challenge to this group of participants. All of them spoke English language and other languages including Norwegian. Their conditions, whether tropical or not, were properly taking care of according to the results obtained from the study. Two of them shared similar experiences as:

The workers are very different from those in my country. This people are so respectful and patient. They smile at you and ready to help if you do not know your way round. They are very lovely. My interactions with the staff were cordial, and the workers were willing to provide the best of care. I do not have a problem of communicating in Norwegian, so it makes it easy for to communicate in both Norwegian and English. They attend to all my questions and the service is generally good. (Afi, 30, Ghana)

I do not delay in visiting to my family doctors office anytime one of the kids is sick. The doctors and nurses are very welcoming. There is no form of intimidation, unlike in my country where healthcare workers shout at patients. Everyone is treated with respect and equal here. It does not matter whether you are rich or poor. Health workers treat poor people in Uganda like trash. My condition was a common women condition, and the healthcare workers did not have a difficulty in treating me. They also spoke pretty good English so it was easy for us to communicate (Juliet, 40, Uganda)

These five participants were asked if other Africans had shared their experiences of racial discrimination while using healthcare services with them. All of the respondents indicated they have heard in conversations about incidences that look like racial discrimination from friends and family, but it was difficult to make a judgement as they were not present to ascertain what actually happened. Two participants put it this way:

You see some of these things come up in conversations with some friends and family members. Hmmm, Africans have our own expectations and seem to be on the guard for racism, so any little thing we tend to draw conclusions quickly. It is difficult to believe what they say regarding

discrimination. From my experience with the health system, I think it is far better than how our own people treat us back home in Africa (Ogah, 28, Cameroon).

Africans over drive this issue of racism and discrimination in my opinion. Even our own fellow blacks do not treat us equal back home how much more been in another country. I think what I get here is best compared to my own country. I do not see anything wrong with what they do (Adwoa, 32, Ghana).

On the influence of non-discrimination and use of healthcare services and health outcomes, it is evident from the results that these participants have continued to use healthcare services when the need arises and consider them generally health.

I do not joke with my health and that of my family at all. Anytime we are not well, I book an appointment for us to visit the doctor. My family is me are very healthy. All conditions we had when we arrived first in Norway have been taken care of. It is just the winter season that the kids often get cold (Juliet, 40, Uganda)

I have always used the various healthcare services available whenever I have the need to. I consider myself generally healthy (Afi, 30, Ghana).

When asked what they thought people who complained of racial discrimination did after such experiences regarding the continued use of healthcare services, self-medication was a common theme identified.

I think people resort to self-medication after experiencing what they describe as discrimination. I know some of them request families traveling from Ghana to Norway to bring them medicines which one cannot buy without doctor prescription in Norway (Adwoa, Ghana).

These participants were also asked about how Africans who experience racial discrimination can contribute to reducing it in Norway. All five mentioned reporting to appropriate authorities. Two responses are given below:

If they truly believe they have been discriminated against, then I think reporting it to the head of that particular health facility can be helpful (Ogah, Cameroon).

Just report the person who discriminated against you or showed racism towards you. It's simple. Because all the workers are not the same (Yube, Gambia).

The need for the government to make sure systems are put in place for people to anonymously report cases of discrimination immediately it happens at the health facility was identified by almost of this group of participants. Training of healthcare workers about discrimination and racism should be prioritized by the Norwegian government. Adwoa from Ghana had this to say:

Workers should be adequately informed and trained about it discrimination at the work place.

4.2 Discussion

4.2.1 Experiences and manifestations of Healthcare related racial discrimination

The study recruited and interviewed fifteen Africans living in Oslo, the capital city of Norway. These participants were from five countries, including Ghana, Nigeria, Cameroon, Uganda and Gambia. The researcher explained to the participants what racism/discrimination/prejudice/unequal treatment meant according to the guiding definition used in the study. Participants alluded to the understanding of the concepts before they were each interviewed. The study shows that ten participants have experienced racial discrimination in using healthcare services in Norway, while the remaining five responded otherwise. The findings from this study regarding racial discrimination in Norway confirm similar recent findings by

Mbanya et al. (2019). Participants from that study from sub-Saharan Africa with similar characteristics as participants from this study identified negative stereotypes and discrimination based on their skin colour as major setbacks while using healthcare services. In addition, participants felt racially discriminated against, as healthcare providers did not show any interest in getting to know them as people with dignity, values and preferences during the care process.

Two main themes emerged from both groups of participants (Discriminated and non-discriminated) about what constituted racial discrimination in the present study while using healthcare services. These themes include communication (both verbal and non-verbal) and language barriers.

4.2.1.1 Communication

Verbal and non-verbal communication plays a key role during patient-healthcare system interaction (Adebayo et al., 2020). Several studies have found communication to be a key and standard variable among research participants while exploring the experiences of racial discrimination in their use of healthcare services (Cuevas, O'brien and Saha, 2016; Ha & Longnecker, 2010). Cuevas et al. (2016) have found that African Americans have often complained of poor communication and disrespect from healthcare workers. In other words, patients use communication to assess the quality of care they obtain from healthcare providers. The findings from the present study show that communication was a crucial factor in determining racial discrimination or its absence. Among participants who reported experiencing racial discrimination, unpleasant facial expressions and body language made them feel unwelcomed, as deduced from Oju's expression: *While waiting for my turn, I observed how the doctors came out smiling to welcome and lead patients to the consulting room. It was imposing. Though I did not understand what they said to patients while welcoming them, the smiles on their*

faces made me feel at ease. Nevertheless, I did not get the same welcome I had observed and expected when it got to my turn. The body language and facial expression were hasty. There were no pleasantries. The whole consultation went very fast, and there was no physical examination to ascertain my complaints.

Meanwhile, smiling faces, friendliness, engagement and willingness to answer questions made the non-discriminated group feel treated equally, welcomed and respected as described by Afi from Ghana: *The workers are very different from those in my country. These people are so respectful and patient. They smile at you and are ready to help if you do not know your way around. They are adorable. My interactions with the staff were cordial, and the workers were willing to provide the best of care. I do not have a problem communicating in Norwegian, making it easy to communicate in both Norwegian and English. They attended to all my questions, and the service generally was good.*

Through verbal and non-verbal communication, Africans who use healthcare facilities in Norway can feel whether or not they are receiving quality care and can determine subsequent use of the service. Arnold and Boggs (2019) have found that the value of relational communication while interacting with the healthcare system has significant influences on health outcomes such as patient satisfaction, provider-patient trust, development of rapport and willingness to disclose significant medical history. Communications thus play a significant role in influencing the quality of healthcare provision irrespective of the context (Abioye Kuteyi et al., 2010). Quality communication, or its deficiency, impacts patients' discernments of the healthcare system and service provision during visits. More particularly, implicit and explicit racial inclinations flourish through verbal and non-verbal communication. According to Dovidio & Fiske (2012, p. 948), "Black patients feel less respected by the physician, like the physician less, and have less

confidence in the physician regarding their medical encounters when the physician exhibits greater implicit racial bias". This is evident that racial discrimination in the healthcare experiences of people is manifested communicatively.

4.2.1.2 Language barrier

In a recent study among Africans living in Oslo by Mbanya et al. (2019) to determine the challenges SSAs face in accessing the Norwegian Healthcare system, many of the participants who have accessed healthcare in one way or the other considered racial discrimination as a significant barrier. Specifically, participants reported they face a language barrier where both parties have difficulty expressing and understanding each other, often resulting in frustration and poor treatment quality. These findings are similar to the findings of language as institutional discrimination against Africans living in Norway. Smedley et al. (2003) have found that the inability to ensure culturally and linguistically appropriate healthcare services has been significantly witnessed in racial and ethnic disparities in health. The language barrier is not just a racial issue. It is a potent form of cultural racism associated with discrimination against immigrants who cannot speak a country's official language. According to Lippi –Green (1997), language prejudice has its roots in anthropological linguistics and is grounded in the theory that languages, dialects and accents are constructs that classify people just as race, considering skin colour, nationality, ethnicity and kinship. To an extent, the inability of Africans to communicate in the official national language can be seen as a threat to the way of life of Norwegian society. Gullestad (2002, p.46), who has analyzed how people with immigrants or minority backgrounds never achieve 'true Norwegian' status, suggests that for immigrants with a non-western background to be accepted as Norwegians, they would have had to forgo their cultural heritage and ultimately embrace the 'Norwegian way of life. Trying to fit properly into Norwegian society by learning and speaking the language often leaves Africans feeling unworthy as it is not

easy speaking the Norwegian language. Racial discrimination related language problems thus often have serious consequences for victims. Urciuoli (1996, p.2) suggests that people who face language prejudice are 'judged communicatively incompetent. Their knowledge of language forms is judged inadequate and contaminated: rules are said to be broken, boundaries crossed, languages mixed, and accents unintelligible'. I have a strong Norwegian accent myself and often find it frustrating and dumb when colleagues keep asking for words to be repeated by saying 'huh' or showing a particular facial expression depicting one not understanding what I am trying to say. It often leaves me feeling I am not good enough as a human. There have been times I have considered migrating to an English speaking country where I would feel respected, be not judged and feel human.

The present study has found that it has often resulted in frustration, sometimes both on the healthcare service providers and the recipients. For example, one from the Gambia shared her ordeal: *I did not speak good Norwegian, and the doctor was also not good at English. We tried to communicate, but I felt we did not understand each other. It was a hopeless situation.* Other studies conducted by Straiton, Aambø & Johansen (2019) have similar findings where immigrants have felt racially discriminated due to language challenges within the healthcare sector. Their study finds that discrimination due to limited proficiency in the Norwegian language is associated with poorer health outcomes and affects immigrants' mental health and ethnic minorities.

On the part of non-discriminated participants, the study revealed that those who could speak both Norwegian and English did not perceive any discrimination as witnessed by Afi's expression. *The workers are very different from those in my country. These people are so respectful and patient. They smile at you and are ready to help if you do not know your way around. They are*

adorable. My interactions with the staff were cordial, and the workers were willing to provide the best of care. I do not have a problem communicating in Norwegian, making it easy to communicate in both Norwegian and English. They attended to all my questions, and the service generally was good.

In facilities where the healthcare workers could fluently speak English, participants did not also experience discrimination. Juliet from Uganda buttresses this point with her expression: *I am happy going to my family doctors office anytime one of the kids is sick. The doctors and nurses are very welcoming. There is no form of intimidation, unlike in my country, where healthcare workers shout at patients. Everybody is treated with respect and equal here. It does not matter whether you are rich or poor. Health workers treat poor people in Uganda like trash. My condition was a common women condition, and the healthcare workers did not have difficulty treating me. They also spoke good English, so it was easy for us to communicate (Juliet, 40, Uganda)*

4.2.2 Influence of racial discrimination on subsequent use healthcare services and perceived health outcomes

Not many studies have been conducted to assess the relationship between racism or discrimination and healthcare service use. Ben et al. (2017) published the first systematic review and meta-analysis to establish the link between these two phenomena - experiences of racism and health service utilization. The findings on the influence of racial discrimination on subsequent use of healthcare services in the present study showed that some participants chose to discontinue while others continued to use the service. There was no significant difference between those who discontinued and those who continued. This is similar to the findings of Ben et al. (2017), where the use of healthcare services after experiencing racism was mixed and

largely non-significant. That is to say, that was no significant impact of experiencing racism on healthcare facilities.

However, further analysis of our results revealed that single participants without families most often find alternative means of caring for themselves, such as resorting to self-medication. In contrast, participants with families continue to use healthcare services even after experiencing racial discrimination in those facilities. Further probing from participants who continued to use the services revealed that they prioritized the health of their family members, especially their children, as the central mediating factor for continued use. Like Rob, a 45-year-old man from Uganda with four children, puts it: *you know children are not like adults. They often fall sick, especially in the winter, and require me to accompany them to the family doctor. I ignore these racial issues because of the children.*

The study found that participants perceived their health outcomes to be generally good. The age range of participants, thus 25-45 years, could be a protective factor. Chronic diseases often set in as one advance in age, so it was not surprising to find that they generally consider themselves healthy. Participants, however, mentioned seasonal illnesses like the winter when children often suffer from cold. Some studies have assessed the health outcomes of Africans and minority groups following exposure to racial discrimination and found mental health problems as an expected outcome. Diaz et al. (2015) found that repeated exposure of Africans to racial discrimination in Norway has increased mental health issues. However, this study did not come across this finding among the study participants. It could perhaps be that participants in this study knew the likelihood of being discriminated against due to stories of racism in Europe they might have heard while in their home countries and so have prepared and conditioned their minds for it. This assertion could be supported by Ebe Ano's expression that there *is racism*

everywhere, including the healthcare sector, because it is still the same white people working there. Because of that, I continue to use healthcare services even after experiencing racism and have developed strategies for dealing with it when I experience it (Ebe Ano, 32, Nigeria).

4.2.3 Coping strategies

The results from the study identified two key themes about how Africans cope with racial discrimination. First, confronting perpetrators of the racial act and avoiding or pretending as if nothing happened were themes that were identified under coping strategies.

4.2.3.1 Confrontation

Experiences from the civil rights activists' movement of 1960 in the United States suggests that confrontation can, to an extent, be a powerful tool for social change, including prejudice and discrimination. Activists used confrontational strategies such as protest rallies, sit/ins, boycotts and marches to render their displeasure of inequality and discrimination orchestrated by the government. These strategies yielded effective results as they resulted in the abolition of legalized government-sanctioned discrimination and a subsequent social climate with resilient norms against overt and hostile expressions of prejudice (Czopp & Monteith, 2003). This climate did not, however, result in the elimination of individual prejudice and or discrimination. Theorists such as Gaertner & Dovidio (1986); McConahay (1986) submit that prejudice often resides "underground" as opposed to eradication and that there continue to persist subtle manifestations. Only one out of the ten who experienced racial discrimination immediately confronted the perpetrator in the present study. The participant painfully narrates how she had heard good remarks about the doctor from her Norwegian friends, only for the doctor to treat her otherwise. She expressed herself as: *The reaction on her face and body gestures while welcoming and leading me to the consulting room communicated her disgust in seeing me. I*

quickly confronted her because I know those eastern Europeans are very racist against blacks, and that was precisely what she did to me. As a nurse myself, I know how patients are welcomed into doctors' consulting rooms, so I told her my peace of mind and angrily left the health facility.

While confrontation will not eradicate it overnight, as suggested by Gaertner & Dovidio (1986), it will raise awareness that Africans know their rights and demand them, especially in a sensitive and vulnerable situation like healthcare use. I am not so surprised that the participant was bold to confront the situation because she has lived, schooled, and worked in Norway for fifteen years. Apart from her fluency in the Norwegian language, she doubles as a nurse and is familiar with healthcare. I feel it was also an opportunity for her to fight on behalf of the numerous fellow Africans she might have witnessed suffering discrimination in her line of work.

Confrontation, most often than not, has its consequences. The victim becomes angry and emotional, and as a defense mechanism, perpetrators, on the other hand, might react back. Czopp et al. (2006) suggested that anger and emotional disturbances emanating from confrontations could result in physical confrontations. Further probing from the participant in this present study revealed that the perpetrator (doctor) realized she had 'misbehaved towards the wrong person' and hence resumed an apologetic posture. The doctor did not, in this case, 'fight' back, but it left the victim in anger and emotional imbalance as she abandoned the consultation and angrily left.

4.2.3.2 Avoidance Strategy

Remaining quiet and pretending as if nothing happened is one of the strategies identified as a coping mechanism when participants experienced racial discrimination in the healthcare sector. The findings from Czopp et al. (2006) support the findings in the present study. Czopp et al.

(2006) found in their study that most people choose to remain silent rather than confronting the situation when they experience racism and or discrimination. This strategy which could be adopted in the long and short term is effective, especially in situations where an immediate reaction might not result in a healthy outcome (Brondolo et al., 2009). The majority of the participants, including those who had reported not experiencing discrimination, felt the best way to deal with racial discrimination is by avoiding the situation. This strategy does not only help avoid a confrontational situation and seems to give inner peace to Africans. One participant's expression deduced this: *I know I am black, and I cannot change my colour. Whites always look down on us and treat us differently. It is something that has become normal for them and us. I do not see the need to confront; it is better to ignore and live my life in peace. Language barriers seem to mediate when Africans ignore discriminatory acts (Ebe Ano, Nigeria).* One participant said I could not even communicate well with the health workers. *We try to understand each other using my 'broken' Norwegian whenever I go to the health facility. I am already struggling to speak Norwegian, so in which language I will use to confront them. It is just unnecessary stress to go confronting these people to treat you equally. Better to just develop a thick skin and pretend as if there is nothing wrong (Adwoa, Ghana).* From my personal experience as an African, we are not used to going to health facilities for routine check-ups. We often visit the health facility because we have a condition that we have tried managing at home but with no effective results. That is to say that Africans would most often be vulnerable or in pain depending on their sickness during their visit to the health facility. Therefore, they would not be able to 'fight' as they need help to relieve their pain or get well from their condition. Any other happenings, including discrimination, would not be of interest to them at that material moment.

Another reason participants choose to remain silent and avoid confrontations is to maintain good relationships with healthcare providers. Africans generally believe in maintaining good relationships with people they come across in life. A common saying in Ghana is quoted as 'you do not destroy where you eat every day'. Applying this thinking to the healthcare setting, Africans would think that it is essential not to have problems with your healthcare provider, especially family doctor, because one would always come back to them for health help when the need arises. The family doctor office is the first point of call when one is sick. With this in mind, one would consider a good relationship by pretending that no discrimination exists over a confrontation that can destroy a relationship. The expression of Philip from Cameroon buttresses this point: *He cannot do what he did to me to a white person. I felt discriminated against for him thinking that Blacks are solid people and manage to work with my pain. We both laughed about it, but I was not happy within. I wanted to keep a good relationship because of the family.*

The organization of the Norwegian healthcare system where it only a primary healthcare provider, in this case, one family doctor who can refer patients to specialist health services at the hospitals, could be a mediating factor for which Africans might choose to remain silent when they experience racial discrimination. A participant shared her feeling this way: *I keep quiet for fear of being denied proper treatment. I am angry within, but what can I do? (Ebe Ano, Nigeria)*

4.2.4 Knowledge about Discrimination/Racism as a violation of human rights

Human rights are the foundation of justice, freedom and peace in the world. These rights are fundamental rights that every individual is entitled to irrespective of their attributes like gender, age, religion, ethnicity, disability, gender orientation or belief. It is the responsibility of the concerned authorities to safeguard human rights and provide protection against abuse,

discrimination, inequality, racism and is a fundamental tenet of a democratic country (Freeman, 2017).

In order to deal with racism, one's knowledge and or awareness of existing and applicable human rights is vital. Therefore, the study sought to find out whether Africans living in Norway were aware of human rights relating to racism and discrimination and to what extent they make use of institutions responsible for safeguarding and upholding such rights. All fifteen participants responded that they knew discrimination based on their race violated their human rights. Participants are thus conversant with the fundamental basis of all Human Rights as declared by the Universal Declaration of Human Rights (UDHR), that 'All human beings are born free and equal in dignity and rights' (UDHR, 1948, p.v). However, some participants were skeptical about the true reflection of the right to non-discrimination in reality and its applicability to all humans as suggested by Rose from Uganda: *Oh yeah, I know racial discrimination is a violation of one's human rights because all humans are equal. However, hmmm, are we equal?* Probing further, she says, *you know we Africans have been presented as animals. No wonder some whites treat us as if we are nothing.* Another participant shared what she called an honest opinion regarding human rights in theory and practice: *In theory, I know discrimination or racism is a violation of human rights, but I think this violation is not for everyone. I think it is instead a violation of white people rights, not us black people. What rights do we have? Nothing! They know blacks do not have that confidence to speak up and so look down upon us. I believe that all human beings were created equal, so we should treat each other as equals, which is also in human rights documents* (Oju, Nigeria).

I share in the argument that it is one thing having the rights enshrined in documents and another thing realizing these rights. In the case of the right to non-discrimination, it becomes more

difficult for Africans because of the social construction of what an African is. Who wants to treat an African who has been socially constructed as an animal in the past equally? These constructions are not entirely erased from the minds of 'white' people and could be the reason why Africans are still discriminated against and looked down upon. I have had my share of this experience where people think that dark skin is dirt. A number of my patients (elderly over 80 years) have tried rubbing my skin while providing healthcare to them to ascertain whether it is dirt or what. Even smelling good was a big shock to a patient; I could sense her expression and facial look. She perhaps had never thought that a Blackman could ever smell good like that. This patient later confided in me that she wants the son to smell good like me and help her select a similar perfume for the son.

There are many states, local and international organizations in Norway involved in human rights activities. When participants were asked about these organizations, the majority of the participants knew these organizations and their names, while the remaining five knew about the existence of these organizations but not their names. Organizations mentioned by participants include the office of the OMBUDSMAN for Human Rights, the United Nations High Commissioner for Refugees (UNCHR), Integration and Diversity Directorate (IMDI), Norwegian Centre for Human Rights, Organisasjon mot Offentlig Diskriminering (OMOD), Anti-Racist Centre, Norwegian Directorate of Immigration (UDI) and workers organization in Norway, Landaorganissajon (LO). These organizations are engaged in anti-racism and discrimination in Norway through several engagements. When participants were asked how they got to know the existence of these organizations, electronic and print media was found to be the most typical means by the majority. Some participants mentioned social media handles such as Facebook and Twitter, while some indicated they had heard of them from friends and families.

Regarding whether or not participants had come into contact with any of these organizations in one way or the other, the study found that none of the participants had contacted any of the organizations for advice, support or help.

In Norway, Anti-Discrimination Laws regulate anti-discrimination and gender equality rules related to gender, identity, age, race, religion, ethnicity or a combination of these grounds (Chhabra, 2019). The Norwegian government is focused on promoting equality and the improvement of anti-discrimination that safeguards all people. As discussed earlier, The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted by Norway on 5th of March, 2002 and became a part of the Gender Equality Act incorporating into the Human Rights Act. The Equality and Anti-Discrimination Act came into force in 2018 in Norway, and the authority of the Anti-Discrimination Tribunal enforced this act followed by Equality and Anti-Discrimination Ombud Act (Chhabra, 2019). This legal protection against discrimination has been strengthened through a law that focuses on discrimination in all areas of society. Awareness of Africans living in Norway about these protective laws could influence how their response to racial discrimination when encountered. While all participants knew there are laws for safeguarding human rights in Norway, they could not mention the specific law or act.

Various Norwegian governments have put forward many action plans against racism that strengthen to eliminate discrimination. The government is putting into efforts to promote inclusion and integration of the immigrant population in all spheres of society. They are aimed at preventing discrimination and offering minorities the same opportunities and protection as the general population. Anti-Discrimination and Accessibility Act, 2013 was amended to promote equality irrespective of all grounds having equal rights, opportunities, accommodation and

accessibility (Grue, 2010). Ethnicity Anti-Discrimination Act, 2013 prohibits discrimination based on religion, ethnicity or belief, language, colour, origin and descent. Furthermore, the anti-Discrimination and Accessibility Act, 2013 prohibits any sort of discrimination irrespective of any disability.

The role of the Equality and Anti-Discrimination Ombud is to represent the interests of those who are discriminated against. It also works to prevent discrimination and promote equality in Norway based on gender, ethnicity, religion, disability, sexual orientation, gender identity, gender expression and age. Furthermore, it is the role of the Ombud to ensure that Norway safeguards human rights following three UN conventions: "Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); Convention on the Elimination of All Forms of Racial Discrimination (CERD); and Convention on Rights of Persons with Disabilities (CRPD). We report directly to the UN on to what extent the Norwegian government upholds these three conventions". The organization also offers free guidance and advice to individuals who have experienced discrimination and wish to take up the matter at the Equality and Anti-discrimination tribunal (The Equality and Anti-Discrimination Ombud, n.d). Unfortunately, only two of the participants knew about the existence of the Ombud. When probed to find out how they got to find out about the Ombud, it was revealed that it came up during a discussion in class when they were taking their master degrees. However, these participants had not contacted the organization for support whatsoever.

CHAPTER FIVE: CONCLUSION & RECOMMENDATIONS

The critical race theory has been the main guiding framework of this study. Applying this theory to African healthcare use experiences, the study highlights the critical dimensions of racial discrimination in African experiences while using healthcare services in Norway. According to Delgado & Stefancic (2012), one of the critical arguments of the CRT is that racial issues and racism have eaten into the core and fabrics of our institutions and structures to the extent that they have become normalized. Norway, unlike many countries, has a universal healthcare system for all legal residents, including Africans living in Norway. Therefore, one can argue that access to publicly available healthcare services is not a challenge for Africans living in Norway. Nevertheless, based on the well-documented existence of racism and discrimination in sectors such as employment, housing and transport against Africans in Norway, it is equally important to explore Africans experiences of discriminatory racial issues at the point of using healthcare services in Norway. To answer the overarching research question, this study employed the CRT to identify the dimensions of racial discrimination that are present in healthcare institutions while demystifying the ideology of colour-blinded healthcare system - the notion of a racially neutral and democratic social order that works for all people (López, 2003, p. 83).

5.1 Conclusions

The findings from this study have established racial discrimination against Africans living in Norway when they are using healthcare services. Racial discrimination against Africans is mainly manifested through communication (verbal and non-verbal) and through systemic structures where the language barrier is the primary discriminating factor against Africans when using healthcare services. The experiences of racial discrimination in the healthcare sector are part of a broader racial discrimination issue in Norway. The 2015 European Commission against Racism and Intolerance (ECRI) report found that the majority of immigrants in Norway, to an extent, have experienced discrimination in the housing, employment and healthcare sectors. Meanwhile, as an egalitarian welfare state, Norway portrays itself as a country where every individual has the opportunity to excel irrespective of their background, race/ethnicity, sexual identity and gender, yet discrimination against immigrants, including Africans, remains a challenge.

What is more worrying is that the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) and Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) has been implemented in the Norwegian law under the 2018 Equality and Anti-Discrimination Act yet racial discrimination linger on. Could it be that racism and racial issues have become as normalized in Norwegian society as suggested by the scholars of CRT and that people see nothing wrong with it? Could the fact that the term «race» has been removed as a concept in Norway's official language, in legislation and the constitution be playing a significant role in the denial of racism in Norway? Comments from some of Norway's politicians seem to be justifying these claims about the denial of the existence of racism and discrimination in Norway. For example, a top parliamentary member for the FRP

who had earlier served as justice minister openly wrote on social media that he had "zero respect."[14] For his thousands of fellow Norwegians who were out demonstrating "against a racism that does not exist in Norway" during the black lives matter demonstrations in Norway. Even worsening the situation is when another top conservative MP who serves as the party's spokesperson on immigration issues backed these claims by denying the existence of 'systematic racism' in Norway[15].

The denial of racial discrimination by persons who influence the development of policies could account for systemic discrimination discovered in this study. CRT offers an opportunity for systemic structures that disfavour racial minorities and, in turn, promote racism to be highlighted and brought to the fore. Delgado et al. (2017, p.8) explain explicitly that 'this notion of the ordinariness and normality of racism in the society advances the 'colour-blind, or 'formal', conceptions of equality, expressed in rules that insist only on treatment that is the same across the board, can thus remedy the most extreme forms of discrimination'. In other words, people of colour are indiscriminately ignored when developing social policies simply because an individual (white) person 'does not see race' and therefore 'is not racist' (Wesp et al., 2018, p.321). In this study, we see that Africans inability to speak the Norwegian language when they attend healthcare facilities were perceived as discrimination against them, including a loss of dignity and a feeling of not being wanted in Norway.

The study has also revealed that racial discriminatory episodes during healthcare services often result in short-term and long-term adverse effects. We also found instances where participants

[14] https://www.newsinenglish.no/2020/06/25/norway-comes-to-grips-with-racism/ accessed on 09.08.2021

[15] https://www.newsinenglish.no/2020/06/25/norway-comes-to-grips-with-racism/ accessed on 09.08.2021

have no option but to continue using the healthcare services. Instant and or short term effects have often been anger and despair and leaving the healthcare facility as one participant narrated her ordeal. The participant revealed how angry she became after her expectations of a wonderful experience based on what her fellow 'white' friends had told her about the doctor was met with 'hardcore' discrimination based on her colour. She narrated how she angrily spoke her peace of mind to the doctor and left the consulting room. Luckily she did not have a condition requiring immediate care otherwise the consequences could have been serious. Among participants who endured such experiences without talking about them, most decide to resort to self-medication. Unlike these groups of participants, pregnant women, on the other hand, cannot walk out or resort to self-medication but instead continue to use such services. The negative influences of racial discrimination have both effects on the individuals involved and the entire healthcare system. Avoiding the healthcare system for fear of discrimination can result in the late detection of diseases that could have otherwise been cured timely. Many resources, including money and time, are often required to manage such conditions.

Avoidance is the primary strategy used by participants in dealing with racial discrimination experienced during healthcare usage. Avoidance strategy is most familiar as only one participant reported how she openly confronted the situation and left. It is not surprising that she had the power to confront the situation, as she is a practicing nurse in Oslo and knows the laws and rights regarding patient care. In addition, she was at the health facility for a routine health check compared to the other participants who required immediate care due to pregnancy or other conditions of their children.

Avoiding the situation most often happens because all one wants is to be relieved in a sickness or immediate care situation, and nothing else matters. More so, the organization of the healthcare

system is different from what Africans are used to in their home countries; booking appointments ahead of the consultation, and only family doctors can refer patients to specialist units at hospitals. All these in mind, Africans requiring care would rather avoid confronting any act of racial discrimination and instead get the care they need. It is not that they are not hurt by the discriminatory act but for the sake of their health or that of their children that they choose to avoid the situation.

5.2 Recommendations

According to the Norwegian directorate of health[16], patients have the right to receive information about their health, illness and treatment in a language they understand, and in this regard, such patients are entitled to an interpreter in a preferred language while accessing care. The directorate further indicates that it is the patient's responsibility to inform the healthcare provider which language they prefer. In theory, the health system has a measure to help eliminate institutional discrimination related to language issues. On the other hand, the challenge is that most immigrants are not aware of this provision, and healthcare providers do not often provide this information. I am personally a frequent user of healthcare services in Norway and never on any occasion have been told about this right and allowed to determine which language I feel comfortable with. Healthcare providers at the family doctor's office have always asked me 'which languages do you speak?' then I respond 'English and little Norwegian' then they conclude by saying' we shall try with both'. While the Norwegian government is making efforts to ensure effective communication and understanding by putting in place the necessary laws and regulations, I will recommend that immigrants should specifically be told ahead of their appointments to the health facility about their right to request for an interpreter and be assured

[16] https://www.helsenorge.no/en/health-rights-in-norway/right-to-an-interpreter/#who-pays-for-the-interpreter

that the interpreter is a trained professional who shall maintain confidentiality. Regarding prejudice and lack of interest and body and facial expressions, conscious discussion about the discrimination at workplaces, a genuine show of interest by policy makers and health leaders and training of healthcare providers' about racial discrimination can help reduce the canker. Opportunities to confront and instantly report these acts shall encourage victims to bring them to the attention of healthcare providers. Open communication and notices of zero tolerance for discrimination boldly inscribed on walls of healthcare facilities will bring also people's attention to it.

A channel to anonymously report would help deal with racial discrimination. For example, use of designated boxes at health facilities for dropping complaints on discrimination shall encourage Africans who for the fear of receiving inadequate care to report it. Leaders of health facilities can then subsequently bring workers' attention to the situation and collectively work to reduce the canker.

Safeguarding the rights of persons, including Africans living in Norway, is a core duty of the state. It thus has to ensure that necessary laws and Acts are available and accessible to Africans. While there are materials available in Norwegian and some minority languages, not all Africans can read and understand these languages. A translation of the Equality and Anti-Discrimination Act into languages Africans can appreciate is a good starting point in raising awareness. Apart from that, public campaigns by NGOs, discussions on media platforms, including electronic and print media, would go a long way to enlighten more Africans about racial discrimination.

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APPENDIX I

Healthcare racial discrimination Experiences among sub-Saharan Africans living in Norway

Interview Guide

Background information

- Age
- Gender
- Marital Status (married, cohabitation, separated, widowed)
- No. of Children, if any
- No. of years or months in Norway
- What was your purpose for coming to Norway? (Family reunion/student/work/refugee/asylum)
- Which of the healthcare services have you come into contact with in Norway? (family doctor, hospital, emergency department, reproductive health services etc)
- How often do make use of the health care services in a year?

Experiences of racial discrimination while accessing healthcare services

- Have you in any way felt or experienced some form of discrimination/racism/prejudice/unequal treatment while using any of the health services you mentioned?

If **YES**, use interview guide **A**

If **NO**, use interview guide **B**

Interview Guide: A

EXPERIENCED Discrimination/Racism/Prejudice Participants

- Which of the healthcare services did you use where you felt discriminated/raced/prejudiced/unequally treated against?
- Was it your first time using that service?
- How was the discrimination/racism/prejudice expressed?
    - Was it verbal, facial or other form expression from the health worker/s?
- Why do you think you were discriminated/raced/prejudiced/unequally treated

Racial discrimination influence on the use of healthcare services and health outcomes among SSAs

- Did the discrimination/racism/prejudice/unequal treatment influence the healthcare services you received? If yes, explain further
- Did the discrimination/racism/prejudice/unequal treatment influence your health outcomes? If yes, explain further
- Has the discrimination/racism/prejudice/unequal treatment you experienced influenced your use of healthcare services after that experience?

Coping strategies adopted in dealing with racial discrimination and avoiding discrimination while accessing healthcare services

- How did you handle the discrimination/racism/prejudice/unequal treatment you experienced while using healthcare services?
- Do you know other ways other SSAs have handled discrimination/racism/prejudice while using healthcare services?
- How can you contribute to preventing discriminated/raced/prejudiced/unequally treated against others?
- What do you think health authorities in Norway should do to prevent discrimination/racism/prejudice/unequal treatment against people accessing healthcare services?

Awareness of racial discrimination as a violation of human rights and institutions responsible for dealing with such violations and providing support

- Do you know that discrimination/racism/prejudice as a violation of one's human rights? If yes, explain further
- Do you know any international organizations/N.G.Os which advocates against discrimination/racism/prejudice in Norway? Can you mention some of the organizations you are aware of?
- Do you know that discrimination/racism/prejudice against an individual is criminal act in Norway?
- Do you know about the Norwegian Equality and Anti-Discrimination institution which has an appointed Ombud where you can seek redress through the tribunal for an act of discrimination/racism/prejudice against an individual in Norway?

Thank you for your time

Interview Guide: B

NOT Experienced Discrimination/Racism/Prejudice Participants

Experiences of racial discrimination while accessing healthcare services

- Which of the healthcare services did you use where you felt **NO** form of discrimination/racism/prejudice?
- Was it your first time using that service/s?
- What about the health workers made you feel **NOT** discriminated/raced/prejudiced against at the facility?
- What about the healthcare structures such as knowledge about disease condition (if tropical disease) etc. made you feel treated equally at the facility?

Shared experiences of others

- Have you witnessed or has anyone from SSA shared their experience regarding Discrimination/Racism/Prejudice with the healthcare system with you before? If yes, where and what was their experience?
- Why do you think they were discriminated/raced/prejudiced/unequally treated against?

Racial discrimination influence on the use of healthcare services and health outcomes among SSAs

You have indicated that you have **NOT** experienced any form of discrimination/racism/prejudice while using healthcare services in Norway:

- How has this influenced your use of healthcare services?

- How has it influenced your health outcomes?

If indicated that others from SSA have shared their experience with the healthcare system with them: how do you think their experience has

- Influenced their use of healthcare services?
- Influenced their health outcomes

Coping strategies adopted in dealing with racial discrimination or avoiding discrimination while accessing healthcare services

- How do you think SSAs handle the discrimination/racism/prejudice/unequal treatment they experience while using healthcare services?
- How do you think SSAs can contribute to preventing discrimination/racism/prejudice/unequal treatment against others?
- What do you think health authorities in Norway should do to prevent discrimination/racism/prejudice/unequal treatment when people are accessing healthcare services?

Awareness of racial discrimination as a violation of human rights and institutions responsible for dealing with such violations and providing support

- Do you know that discrimination/racism/prejudice as a violation of one's human rights? If yes, explain further
- Do you know any international organizations/N.G.Os which advocates against discrimination/racism/prejudice in Norway? Can you mention some of the organizations you are aware of?

- Do you know that discrimination/racism/prejudice against an individual is criminal act in Norway?
- Do you know about the Norwegian Equality and Anti-Discrimination institution which has an appointed Ombud where you can seek redress through the tribunal for an act of discrimination/racism/prejudice against an individual in Norway?

Thank you for your time

Norges miljø- og biovitenskapelige universitet
Noregs miljø- og biovitskapelege universitet
Norwegian University of Life Sciences

Postboks 5003
NO-1432 Ås
Norway